Central East **LHIN**

Integrated Health Service Plan 2010-2013

Engaged Communities. Healthy Communities.

November 2009

Ontario
Local Health Integration Network

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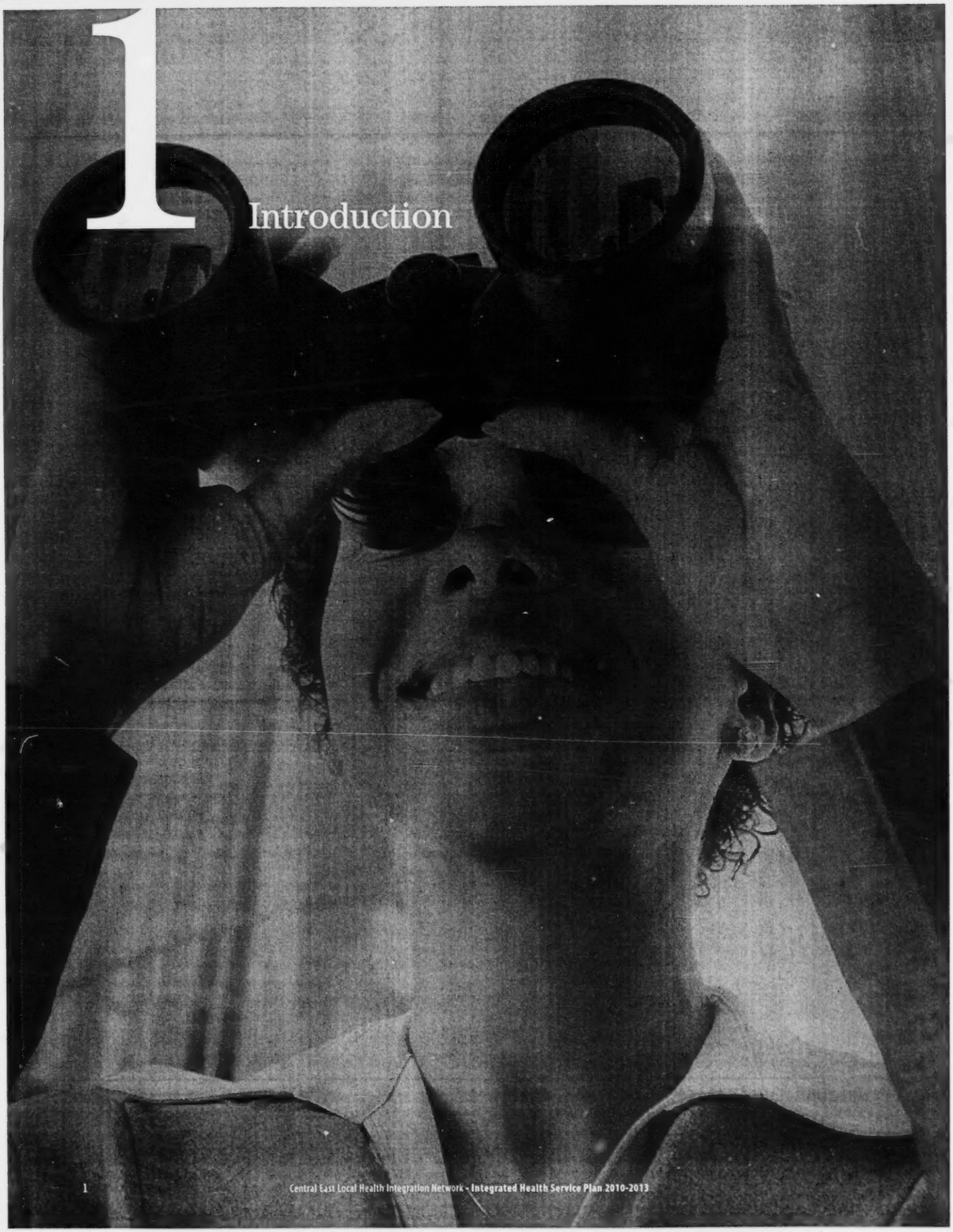


1 Introduction

Introduction

Welcome to the 2010-2013 Central East Local Health Integration Network's (LHIN) Integrated Health Service Plan, a local road map to better health, better care and better value-for-money for the health care dollar, for the residents and health service providers in the Central East region! The strategies, projects and improvements presented in the Integrated Health Service Plan (IHSP) are rooted in the common vision and priorities of the Ontario Ministry of Health and Long-Term Care and the Central East LHIN, as well as in evidenced-based and leading edge practice in the planning and delivery of health services.

Most importantly, the IHSP is informed by those people who directly deliver and receive health services each day in the Central East LHIN. Patients, clients, caregivers, allied health, administrators, nurses, physicians and community leaders played a significant role in the creation of the IHSP, and we expect will play an even bigger role in the achievement of the IHSP's objectives!

The IHSP is a three-year strategic plan for the Central East health care system. Like all of the province's 14 LHINs, the Central East LHIN has developed the IHSP to guide the activities and accountabilities of local health service providers as described in the *Local Health System Integration Act, 2006*. Specifically, it provides an overview of the current health care system, identifies areas for focused improvement, and sets standards for achievement. All of this is done to advance the Central East LHIN vision of "*Engaged Communities. Healthy Communities.*"

Building on the Foundation of the first IHSP: What's the Same? What's New?

This is the second IHSP of the Central East LHIN. While change in the health care system can happen quickly, it is important to know that this IHSP builds on the foundation and progress made by the first Central East LHIN IHSP for 2007-2010. In particular, local health care providers and residents will find the 2010-2013 IHSP to be a recommitment to the Central East LHIN vision and values, and the enduring focus on client-centred care that aims for excellence in outcomes, equity in access, and improved client-experience. Consistent with the first IHSP, this plan continues our focus on improvements in primary health care, community and hospital based care, as well as services to seniors, persons with mental illness and addictions, and the effective prevention and management of chronic diseases.

Apart from the recommitment and continuity referenced, this second IHSP is significantly different than its predecessor. The difference is a result of the significant learning made over the last three years as we have come to know our clients, communities and health care providers better. Through our successes and our shortcomings, we now have a better understanding of how to support change and get results.

The 2010-2013 IHSP is more focused in its direction and approach. It sets out specific activities that we expect will lead to the achievement of specific aims. While system design and planning are no less important today, the emphasis in this IHSP is on achievement over planning. This shift is made possible by the significant health service planning gains that have been made in the Central East LHIN in which over 15 major planning reports have been produced since 2008.

Other subtle changes have also taken place in this new IHSP. Whereas the first IHSP identified Seniors, Mental Health and Addictions, and Chronic Disease Prevention and Management

as "Priorities for Change," we now recognize these client groups as "Priority Populations" to which we are tailoring activities and investments that will result in common outcomes for the Central East LHIN population and health care system. In addition to seniors, persons with mental illness and/or addictions, and people with chronic disease, the Central East LHIN also recognizes the francophone community and our Aboriginal partners as priority populations.

Our Strategic Aims

It is clearly understood that the general public and other stakeholders want to better understand what value the Central East LHIN and the mandate of integration bring to the health care system, and what it aims to achieve "by when" and "by how much." The single most important change in this IHSP is the identification of two system-level strategic aims for the Central East LHIN that are in keeping with provincial and local priorities:

- **Save 1,000,000 Hours of Time Patients Spend in Central East LHIN Emergency Departments by 2013.**
- **Reduce the Impact of Vascular Disease in the Central East LHIN by 10% by 2013.**

Providing greater detail about these two aims and how they will be achieved is the major purpose of this IHSP.

While these aims are focused on hospital emergency department activity and a specific grouping of chronic diseases, they are inclusive of a broad and complex range of health care issues and health care services. Although the symptoms of the problem may be experienced in a specific part of the health care system (such as an emergency department), the sustainable remedy requires the coordination and commitment of many parts of the health care system. It may also require the support of areas outside the health care system, such as public health, education, housing and the environment.

Despite the breadth of these strategic aims, we recognize that some stakeholders may feel that their priorities are not being addressed in this IHSP. We will continue to be responsive to the multitude of local issues in our operations, and new priorities may be established by the Central East LHIN or Ministry of Health and Long-Term Care during the life of this IHSP. However, with finite resources and a need to achieve measurable results, health care must be limited in the number of aims it plans to accomplish. The challenging strategic aims in this IHSP are innovative, based in evidence and leading practice, inclusive of the health care system, and are of relevance to all of our priority populations.

Once again the creation of this plan has been a collective effort. On behalf of the board members and staff, we look forward to working with everyone in our LHIN to achieve our aims.

Foster Loucks
Chair, Central East LHIN Board of Directors

Deborah Hammons
CEO, Central East LHIN

How to Read The IHSP

Section Two provides a brief summary of the Province's vision, strategic directions and priorities and how this IHSP aligns to them.

Section Three continues to demonstrate this alignment by a review of the Central East LHIN vision for the local health care system and how we aim to be a high performing health care system.

Section Four provides an overview of the current health care system. This is in addition to information and evidence presented throughout the report. A comprehensive *Environmental Scan* is available as an appendix to the IHSP and is posted on the Central East LHIN website.

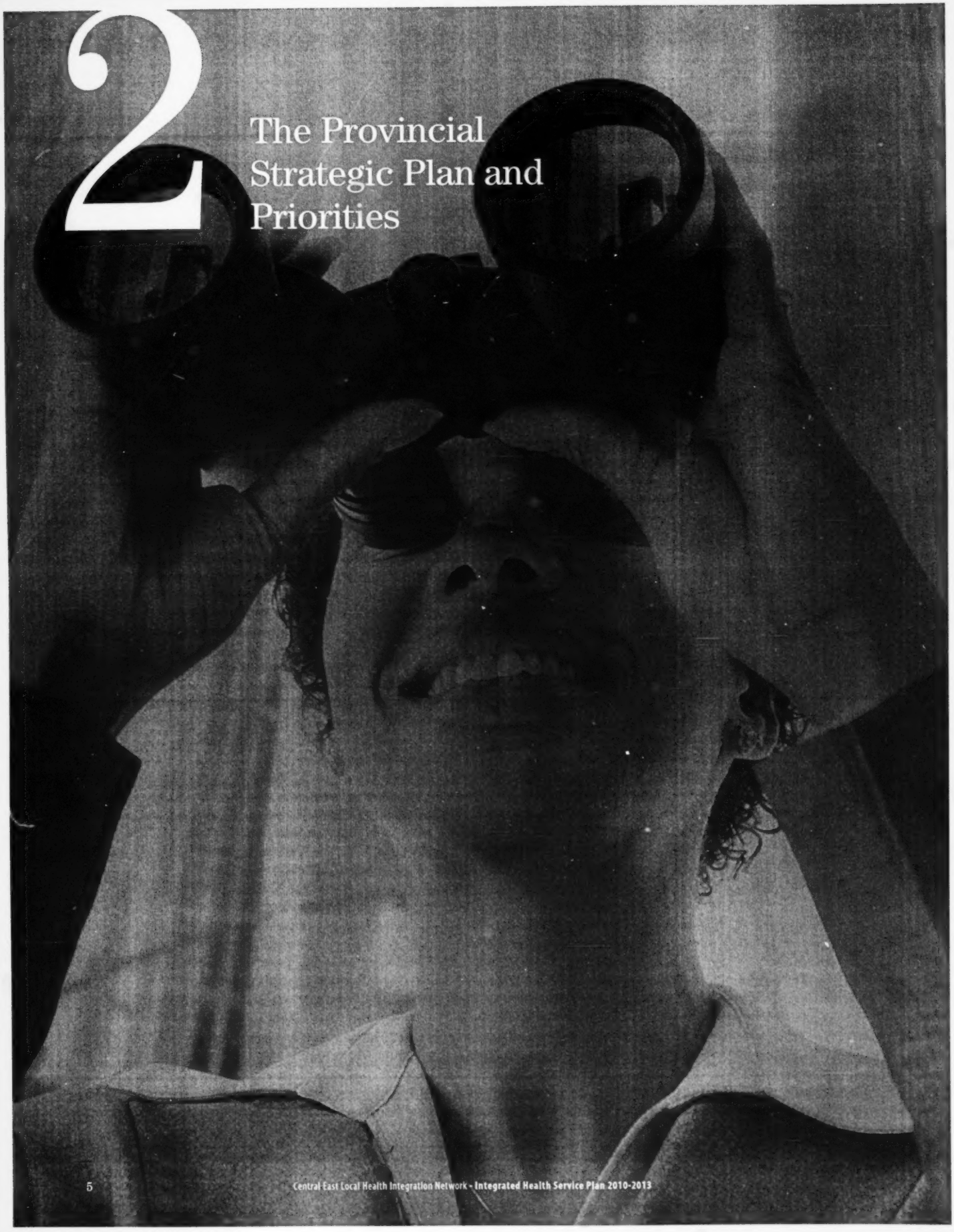
The planning framework and other documents used for this IHSP, specifically the Central East LHIN's adaptation of the Institute for Healthcare Improvement's "Triple Aim", are outlined in *Section Five*.

Based on the application of the Triple Aim framework to the provincial and Central East LHIN vision and strategic directions, *Section Six* outlines the emergency department and vascular health strategic aims of the 2010-13 IHSP.

Section Seven provides an evidenced-based rationale for the emergency department and vascular aims, while *Section Eight* provides specific details on how success will be achieved and measured.

Planning Reports that guide the Central East LHIN

- Alternate Level of Care Systems Issues and Recommendations: Report prepared by the Central East LHIN ALC Task Group
- Emergency Department Task Group Report
- Rehabilitation is a Journey: Report prepared by the Central East LHIN Rehabilitation Task Group
- Hospital Clinical Services Plan – Detailed Report
- Caregiver Support and Well-Being Priority Project
- Community Support Services Review Priority Project
- Supportive Housing Priority Project
- Rural Transportation in the Central East LHIN: Phase One Review
- Assisted Transportation in Scarborough: Preliminary Planning Project
- Peterborough Regional Health Centre Alternate Level of Care Review and Recommendations
- Final Report Early Youth Interventions Project Report March 31, 2009: Transitional Age Youth and Health Promotion
- Addictions Environmental Scan
- Chronic Disease Prevention and Management Framework
- "Planning Framework" for Seamless Care for Seniors in the Central East LHIN
- Every Door is the Right Door Towards a 10-Year Mental Health and Addictions Strategy A discussion paper



2 The Provincial Strategic Plan and Priorities

2

The Provincial Strategic Plan and Priorities

The 2010-2013 Central East LHIN Integrated Health Service Plan provides a local context to the advancement of the provincial Ministry of Health and Long-Term Care vision and strategic priorities.

The Ministry of Health and Long-Term Care Vision

> *"A health care system that helps people stay healthy, delivers good care to them when they need it, and will be there for their children and grandchildren."*

The Ministry of Health and Long-Term Care Strategic Directions

The Ministry of Health and Long-Term Care is developing a 10-year Provincial Health System Strategic Plan. In 2007, in lieu of the future release of this provincial plan, the Ministry provided direction to LHINs on five initial strategic directions:

1. Renewed community engagement and partnerships in and about the health care system;
2. Improve the health status of Ontarians;
3. Ontarians will have equitable access to the care and services they need no matter where they live or their social, cultural and/or economic status;
4. Improve the quality of health outcomes; and,
5. Establish a framework for sustainability of the health system that achieves the best results for consumers and the community.

These directions are consistent with the Ontario Health Quality Council's (OHQC) nine attributes of a high performing health system which have been also adopted by the Central East LHIN performance framework.[1]

The Ministry of Health and Long-Term Care Strategic Priorities

In support of these provincial Strategic Directions, the Ministry has required LHINs to dedicate significant attention to the achievement of three provincial priorities. This IHSP marks a continuation of the efforts and advancements the Central East LHIN and local health service providers have been making in the pursuit of these priorities.

1. Reducing wait times in Emergency Departments

Ontarians are entitled to safe, reliable, appropriate and high-quality care when they visit an emergency department. Because reducing wait times in Emergency Departments can significantly improve a patient's experience, it is one of the Ontario Government's top health care priorities.

In addition, patients with non-urgent or less urgent needs account for about half of all emergency department visits. As a result, LHINs are building alternative but appropriate health care options so people can access care in the community rather than in hospital emergency departments.

1 The OHQC is an Operational Service Agency that reports to the Minister of Health and Long-Term Care with a mandate to monitor and report to the public on the performance of the health care system and health status, and to support continuous quality improvement. See http://www.ohqc.ca

2. Reducing the time patients spend in alternate level of care beds in hospitals

Too frequently patients remain in a hospital acute care bed despite having completed their hospital acute care treatment. These patients are waiting to be discharged or transferred to an "alternate level of care" such as long-term care, rehabilitation, or home care – but none is readily available. Close to 19% of patients currently in Ontario hospital beds are waiting for an Alternate Level of Care (ALC).[2] High rates of ALC not only indicate poor performance in patient experience, quality of care and access to care, but also represent an inefficient use of health care resources. Delays in patient flow out of the hospital also create challenges in the emergency department, creating a longer wait time for those patients requiring admission to a hospital bed.

The LHINs are working with the Ministry of Health and Long-Term Care on a variety of initiatives that will help patients get the care they need – whether that's in a hospital, in a long-term care or rehabilitation care facility, in the community or at home.

3.Improving access to integrated diabetes care

Ontario's Diabetes Strategy will help tackle a growing – and expensive – population health challenge. In 2008, about 900,000 Ontarians were living with diabetes (8.8% of the province's population). The number of Ontarians with diabetes has increased by 69% over the last 10 years, and is projected to grow from 900,000 to 1.2 million by 2010. Treatment of diabetes and related conditions (including heart disease, stroke and kidney disease) currently costs Ontario over $5 billion each year.[3]

The Ontario Diabetes Strategy will improve access to prevention programs and team-based care. One component of the Strategy is an online registry that will give patients access to information and educational tools so they can better manage their diabetes. The registry will also enable health care providers to check patient records, access diagnostic information and send patient alerts. The registry will result in faster diagnosis, better treatment and improved management for Ontarians living with diabetes.

In addition to these three priorities, LHINs are participating in other provincial strategies to improve care for mental health and addictions and build innovative infrastructure through eHealth.

a. Enhancing Mental Health and Addictions Services

About one in five Ontarians will experience a mental health or addiction problem at some time, and the cost to individuals and society is enormous.

The Ontario Government has announced that it plans to enhance mental health and addictions services. The Minister's Advisory Group on Mental Health and Addictions is laying the foundation for a 10-year strategy to address this important issue. For the first time, the province's strategy looks beyond the Ministry of Health and Long-Term Care to include mental health and addictions services funded by other Ontario ministries.

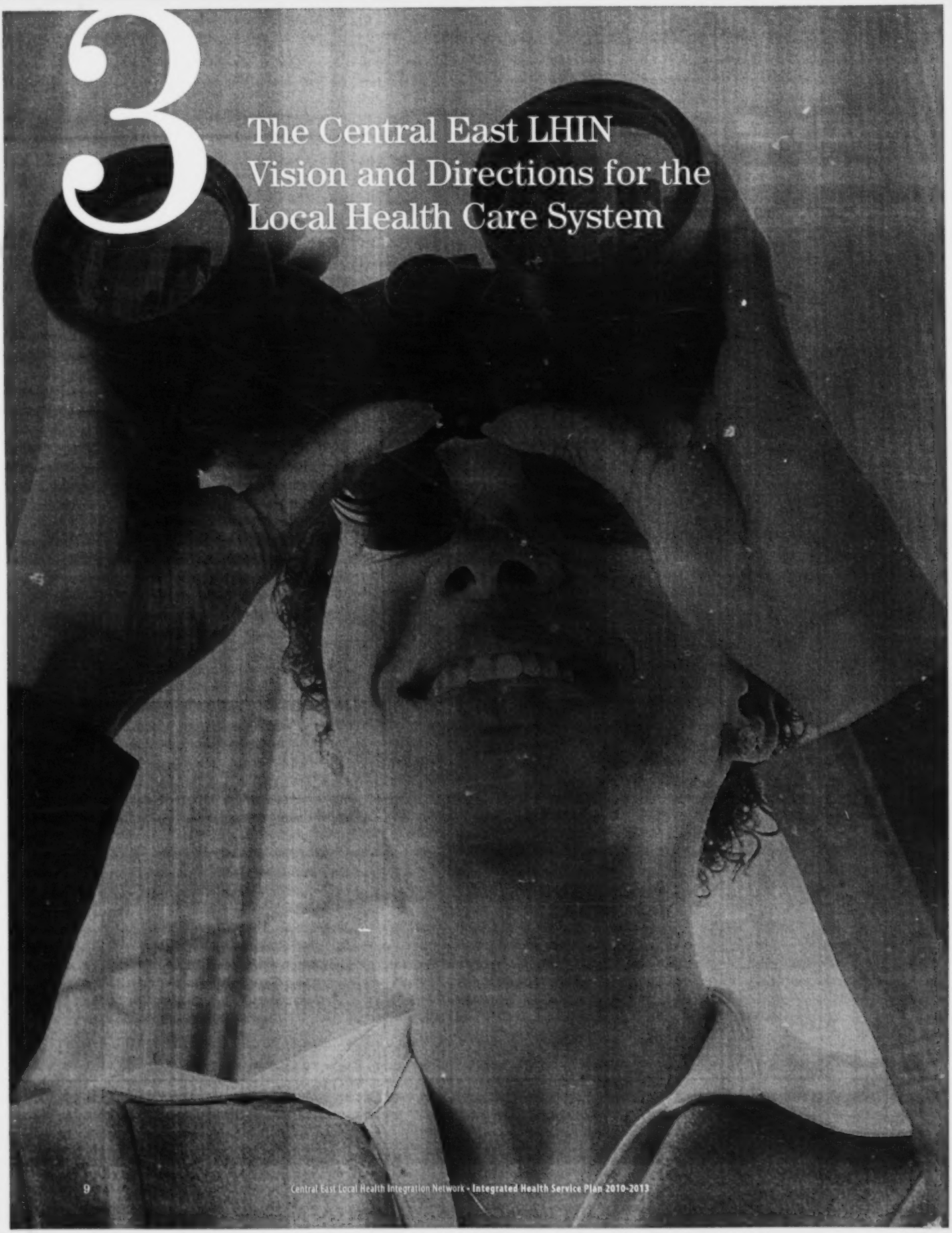
2 Ministry of Health and Long Term Care. Backgrounder: Alternate Level of Care (ALC). May 19th, 2009. Retrieved June 25th 2009 from: http://www.health.gov.on.ca/english/media/news_releases/archives/nr_09/may/bg_20090519_3.pdf

3 Ministry of Health Promotion. Chronic Disease Prevention: The Ontario Diabetes Strategy. Retrieved June 25th, 2009 from: http://www.mhp.gov.on.ca/english/chronic_disease/diabetes/default.asp

LHINs are expected to play a critical role in the eventual implementation of the provincial Mental Health and Addictions Strategy, helping to create a system that provides everyone who needs care with equitable access to safe, respectful and effective services.

b. Building on an eHealth Framework

Ontario's eHealth Strategy supports the province's other strategies. By investing in information technology infrastructure, including the diabetes registry and electronic health records, we can improve patient care and access. The LHINs look forward to building on eHealth Strategy innovations to enhance system-wide integration and improve our health care system.



3 The Central East LHIN Vision and Directions for the Local Health Care System

The Central East LHIN Vision and Directions for the Local Health Care System

In support of the Ministry of Health and Long-Term Care vision and strategic directions, the Central East LHIN Board of Directors has established its own local vision statement, strategic directions and desired outcomes in support of a high performing health care system.

Central East LHIN Vision: *Engaged Communities. Healthy Communities.*

As part of the 2010-2013 Integrated Health Service Plan, the Central East LHIN has reconfirmed the vision statement that it originally created in the fall of 2006. The reconfirmation of this vision is a testimony to the enduring hopes of residents and health care providers to improve the health of our communities through an integrated health care delivery system focused on wellness, equitable and timely access to care, that delivers high quality outcomes. Such outcomes can only be achieved through engagement and partnership with patients and their families, the full range of health care services providers, and other non-health care stakeholders that have a significant impact on the health of individuals and communities. The vision is defined as:

Engaged Communities

People are supported and proactively engaged in

- *Managing their own health and wellness*
- *Providing direction and solutions for their health care system and their LHIN*
- *Coordinating the delivery of timely health care services*

Healthy Communities

- *Supportive and sustainable environments that address the social determinants of health and cultural competency*
- *Timely and equitable access to care*
- *The health of the population has improved.*

Central East LHIN Strategic Directions and Outcomes: Supporting a High Performing Health Care System

To fulfill the LHIN mandate and vision, the Central East LHIN has also adopted four high-level strategic directions that support the achievement of a high performing health care system as defined by the Ontario Health Quality Council. These Strategic Directions and Outcomes are also embedded into the Central East LHIN decision-making process.[4]

Central East LHIN Strategic Directions[5]:

- *Transformational Leadership:* The Central East LHIN Board will lead the transformation of the health care system into a culture of interdependence
- *Quality and Safety:* Health care will be people-centred in safe environments of quality care
- *Health Service and System Integration:* Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes
- *Fiscal Responsibility:* Resource investments in the Central East LHIN will be fiscally responsible and prudent

4. See the Central East LHIN Decision Making Framework (http://www.centraleastlhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/DecisionFrmwk-Oct_2008_-_FINAL.pdf)
5. While an important foundation to the IHSP, the Strategic Directions are not fully articulated or executed through the IHSP. The thrust of the Strategic Directions are incorporated in several LHIN documents and procedures including the Central East LHIN Annual Business Plan, the Central East LHIN Annual Report, and health care governance engagement framework.

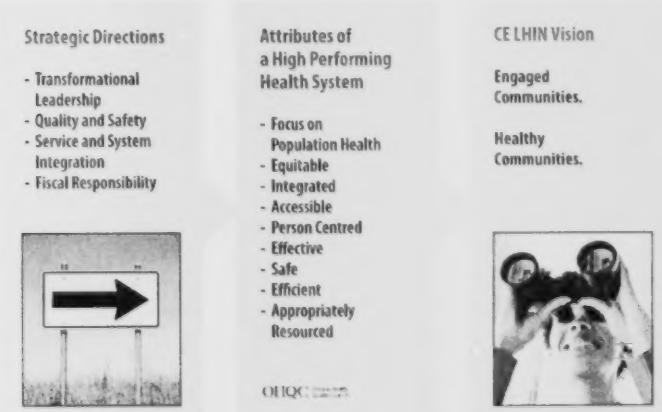
Attributes of a High Performing Health System

- *Focus on Population Health:* The health system should work to prevent sickness and improve the health of the people of Ontario.
- *Equitable:* People should get the same quality of care regardless of who they are and where they live.
- *Integrated:* All parts of the health system should be organized, connected and work with one another to provide high quality care.
- *Accessible:* People should be able to get the right care at the right time in the right setting by the right health care provider.
- *Person Centred:* Health care providers should offer services in a way that is sensitive to an individual's needs and preferences.
- *Effective:* People should receive care that works and is based on the best available scientific information.
- *Safe:* People should not be harmed by the care that is intended to help them.
- *Efficient:* The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time and information.
- *Appropriately Resourced:* The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs.

Creating the 2010-2013 IHSP Strategy Map

One lesson learned from the first IHSP was the importance of creating a "strategy map" that helps to visually capture the interconnection between vision statements, strategic directions, desired outcomes, health care priorities and enablers. The 2007-10 IHSP Strategy Map evolved over the lifespan of that IHSP, and proved to be an invaluable guide to communicate the complexity and comprehensiveness of the IHSP.[6]

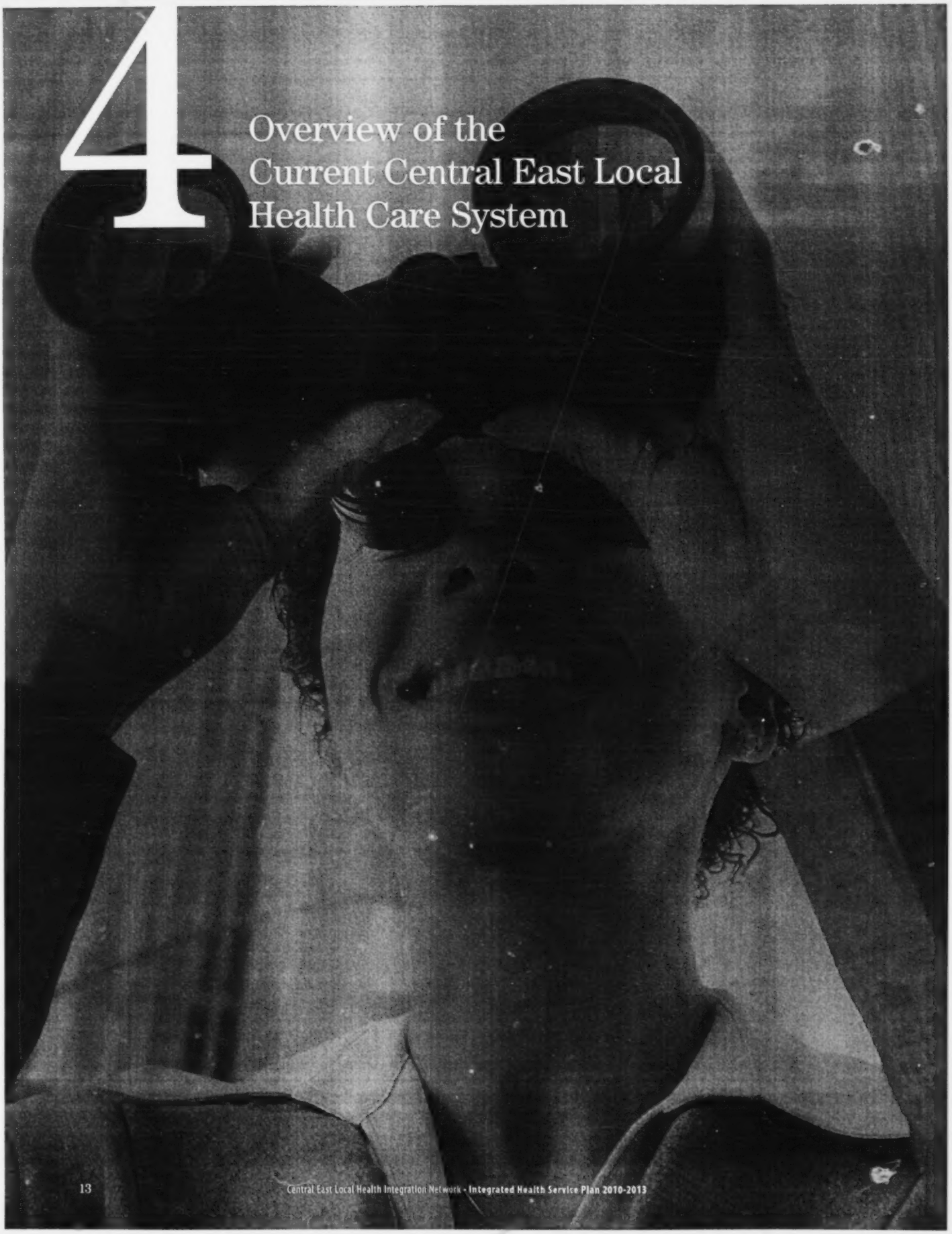
Figure 1: Step 1 of Central East LHIN IHSP Strategy Map



6 2007-2010 IHSP Strategy Map - http://www.centraleastlhin.on.ca/uploadedFiles/Home_Page/Integrated_Health_Service_Plan/2007-2010_Strategy_Map.pdf

With this in mind, **Figure 1** begins to visually assemble the foundations of the 2010-2013 IHSP Strategy Map. In this Strategy Map, the Strategic Directions provide the basis for Central East LHIN decision making that is intended in the short and intermediate term to accomplish elements of a high performing system and which, over the longer term, will achieve the vision of *Engaged Communities. Healthy Communities.* Moving forward, we will build on this model as we further describe our framework for planning and strategic aims of this IHSP.

4 Overview of the Current Central East Local Health Care System



Overview of the Current Central East Local Health Care System

The Central East LHIN is one of the fastest growing geographic regions in the Province and home to over 11% of Ontario's population. Based on the 2006 Census, the population has grown by 6.3 percent, making the LHIN 1.4 million people strong.

The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km^2). In densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements, the Central East LHIN stretches from Victoria Park to Algonquin Park! The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics.

Map of CE LHIN

- The Central East LHIN covers 16,673 square kilometres of land mass and is the sixth-largest in land area in Ontario.
- The CE LHIN geography stretches from the culturally diverse and densely populated Scarborough planning zones to the rural and less populated areas of Haliburton Highlands, the northern sections of the City of Kawartha Lakes and Peterborough City and County.
- Population of approximately 1,432,705 – represents 11.7% of Ontario's total population.
- Central East LHIN has the second highest population within the province.
- Since 2006, Central East LHIN has experienced an increase in population growth, slightly higher than provincial population growth for the past 7 years. Population projections from 2008 to 2033 (5 year projection) indicates that there will be a projected 6% growth with year-to-year incremental increases of 1% to 1.3%.[1]
- Durham is the Central East LHIN's fastest growing region at 22.4% growth in the last 10 years.

[1] Intellihealth 1996 – 2007 from Statistics Canada (1986–2006) and Ontario Ministry of Finance (2001–2007)

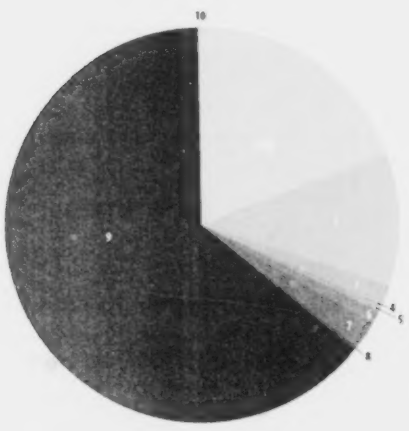
Key Facts about the Central East LHIN from the 2006 Census (Statistics Canada):

- Life expectancy at birth for both females and males is above the provincial average (as per population estimates in 2005).
- Central East LHIN has the second highest number of families with children at home.
- Has the second highest percentage of families with children who are headed by a single parent.
- Has the third highest percentage of the population with no knowledge of English or French.
- Has the third highest unemployment rate (above 15 yrs) within the province.
- Is fifth of all 14 LHINs with the percentage of population (age 25+) who have completed post-secondary education.

The Central East LHIN is responsible for funding more than 170 health care programs/services. They include:

- 10 hospitals operating on 16 sites
- 68 Long-Term Care Homes
- 1 Community Care Access Centre
- 42 Community Support Services
- 3 Acquired Brain Injury Services
- 17 Assisted Living Services in Supportive Housing
- 7 Community Health Centres
- 19 Community Mental Health Programs
- 6 Addictions Programs

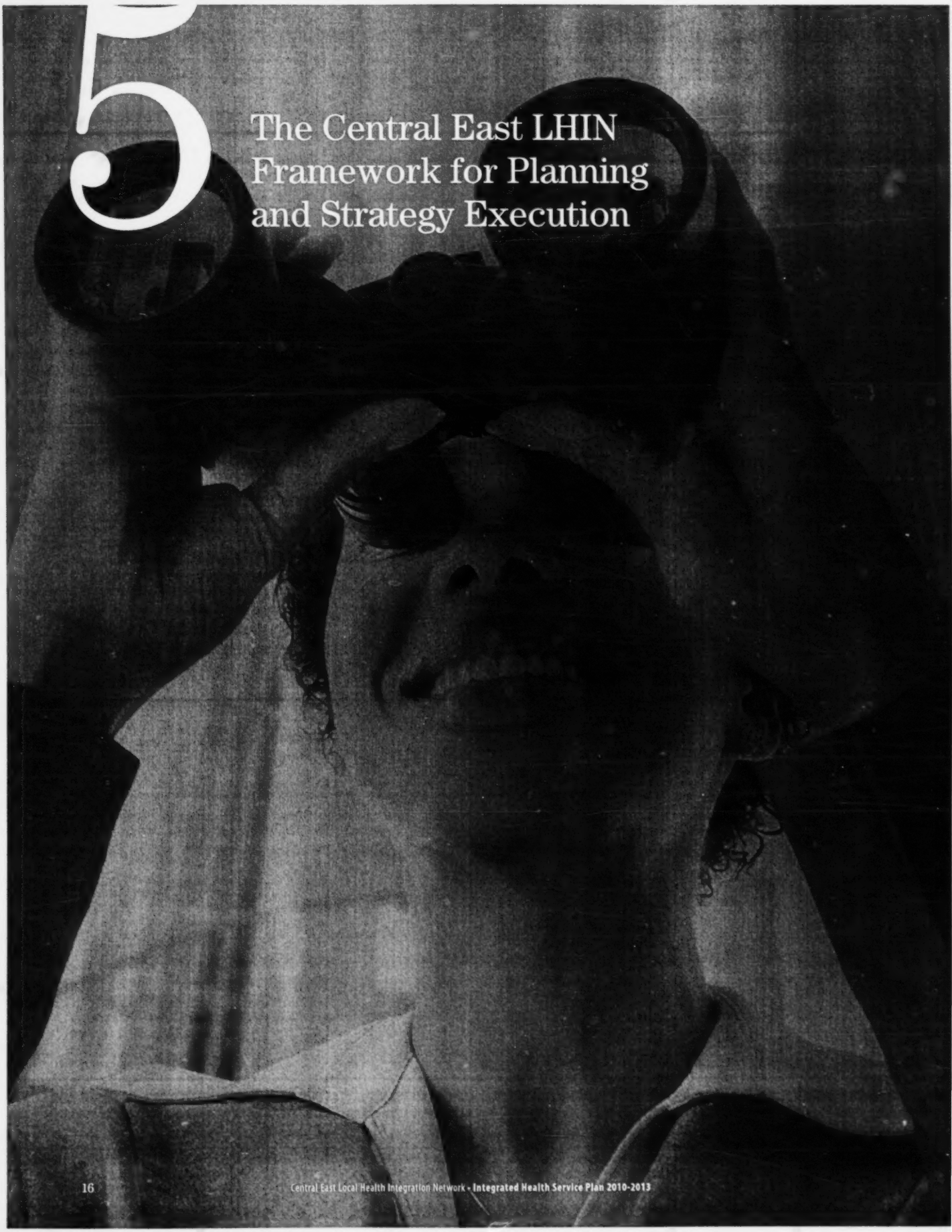
Funding Allocations by sector 2009-10 (as of June 30, 2009)



Sector		Total Funding $
1.	Long-Term Care Homes (LTCH)	365,873,699
2.	Community Care Access Centre (CCAC)	203,198,605
3.	Community Support Services (CSS)	29,282,171
4.	Acquired Brain Injury (ABI)	1,085,549
5.	Assisted Living Services in Supportive Housing (SH)	12,819,887
6.	Community Health Centres (CHC)	17,907,481
7.	Community Mental Health Programs (CMHP)	43,107,935
8.	Addictions Programs	8,035,683
9.	Hospitals (including specialty hospital)	1,202,560,125
10.	Initiatives (unallocated)	4,616,114
Total		1,888,487,249

Demographic information on the Central East LHIN can also be found in the Integrated Health Service Plan Environmental Scan. Additional data relevant to our strategic aims is also available in the Scan.

5 The Central East LHIN Framework for Planning and Strategy Execution



The Central East LHIN Framework for Planning and Strategy Execution

Fulfilling the Ministry of Health and Long-Term Care and Central East LHIN vision, strategic directions and strategic priorities requires a consistent and concise application of a planning framework aimed at strategy design and execution. This framework must not only be based in leading practice and evidence, but it must also be a learning model that allows for continual quality improvement in the achievement of system level aims.

From our beginning in 2006 to the fall of 2009, the Central East LHIN has completed no fewer than 15 major planning documents, frameworks or reports. All of these documents serve as important input into current and future activities of the Central East LHIN.

While reviewing the main findings and recommendations of these reports is beyond the scope of this IHSP, it is important to highlight some of the key documents that will inform Central East LHIN activity in 2010-2013.

Central East LHIN One Acute Care Network: The Clinical Services Plan

The One Acute Care Network is the outcome of the Central East LHIN Hospital Clinical Services Plan (released in February 2009). This plan is the foundation for improved and equitable patient access to an integrated hospital system that provides the highest quality of care across the Central East LHIN for selected services. To achieve this, the Clinical Services Plan explored:

- Improvements in *quality and safety* by grouping together clinical or medical/surgical specialists, their teams and appropriate physical resources;
- Expanding or creating new programs that would not be *viable or sustainable* at multiple sites;
- Creating *operational and clinical efficiencies* that would allow hospitals to focus on, and improve, their core programs;
- New *"centres of excellence"* to allow Central East LHIN residents to receive services within the LHIN and, as close-to-home as possible. This will require the establishment of sub-LHIN clusters in which to organize and integrate health care delivery and leadership at the local, cluster and LHIN-level.

During the course of the 2010-2013 IHSP, the LHIN and its health service providers will focus on prioritizing and staging the implementation of the Clinical Services Plan (CSP) recommendations. Specific attention will be placed on those recommendations that will aid in the achievement of the strategic aims in this IHSP. Using the experience and successes gained in the first round of hospital clinical services planning, the Central East LHIN and its hospital partners will also be considering additional programs to plan for on a LHIN-level basis, further advancing the vision of a One Acute Care Network: *improve equitable and timely patient access to an integrated hospital system that provides the highest quality of care across the Central East LHIN.*

The Framework for Community Engagement and Local Health Planning

It is anticipated that as a result of lessons learned from the first three years of the Central East LHIN, and with the enhanced strategic aim focus outlined in this IHSP, that some revision to the *Framework for Community Engagement and Local Health Planning* will be required. Working in partnership with local Collaboratives, LHIN-wide Networks and Task Groups, we will pursue

options to strengthen community engagement, collaboration and coalition building that will result in measurable outcomes for individuals and families of identified priority populations.

At a minimum, the *Framework* will need to be revised to incorporate new developments in the Central East LHIN engagement strategy, such as the establishment of the Health Professionals Advisory Committee, the French Language Health Services (FLHS) Planning Collaborative, and the Central East LHIN Aboriginal Advisory Circle.[7]

Supporting Better Patient Care through eHealth

The Central East LHIN, with the support of its eHealth lead and local stakeholders, has developed a Central East LHIN eHealth Strategic Plan[8]. In keeping with this Strategic Plan, a number of significant eHealth projects are underway in the LHIN. Examples of these projects include:

- The Diagnostic Imaging Picture Archiving and Communication System (DI-PACS) project, which will provide secure electronic sharing and storage of x-rays, MRI test results and other diagnostic images, is reaching completion in our LHIN.
- The Data Centre Consolidation project is a multi-LHIN initiative to consolidate hospital data centres in 33 hospital sites to a secure site with a backup for disaster recovery. This data centre will greatly improve the efficiency and effectiveness of the infrastructure for these facilities. Our LHIN will use this improved infrastructure to complete a consolidated hospital information system (HIS) that will be shared by all the Central East hospitals, and other agencies as required. This consolidated HIS will provide a single, shared, but secure, health record that details all information available in every hospital in the LHIN. In addition to providing comprehensive information, this approach will also allow for shared workflows and business processes, enabling us to accelerate the integration of our health system.
- Timely Discharge Information System will securely link hospitals to family practitioners in a way that protects the privacy and confidentiality of personal health information, to ensure that hospital information regarding patients is available to the appropriate physician when patients are admitted and discharged from the hospital.

In partnership with eHealth Ontario, we are working on the provincial implementation of programs to support diabetic patients and the practitioners who treat them, wait time management systems, registries of providers, patients, and patients who have no physicians. Another major project, supported by the MOHLTC, is the development of drug information systems to improve the safety and efficiency of our prescribing systems.

Completing the necessary infrastructure and improving the functionality required for eHealth throughout the LHIN is necessary to support the achievement of the broader provincial and Central East LHIN vision, strategic directions and aims.

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7 No final determination has been made with respect to the naming of this Advisory Circle. Local leaders are discussing cultural relevant options that are reflective of "Nishnaabe." Metis, and Inuit communities, tradition and historical fact. "Nishnaabe" is a North American Aboriginal term that is simply translated as "people of the Creator of Turtle Island." First Nations leaders have initially chosen this term to describe their community, including those persons living on- or off-reserve.

8 Central East LHIN eHealth Strategic Plan - http://www.centraleastlhin.on.ca/uploadedFiles/Home_Page/Be_Informed/CEe-HealthStratPlan2007.pdf

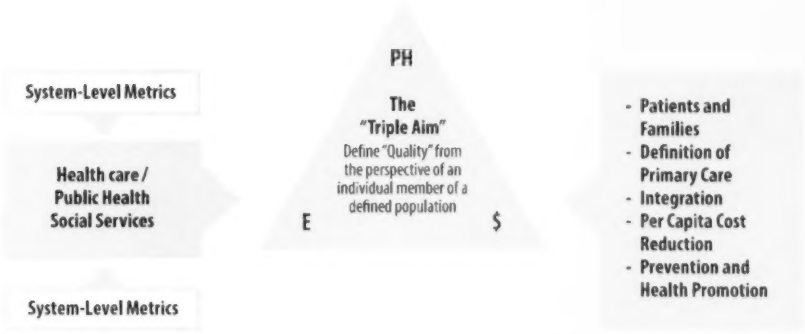
A Framework for System Quality Improvement: Introducing the Triple Aim

Health care planning and decision making that intends to achieve shared goals can be a complex undertaking involving many stakeholders with competing priorities. Planning and priority setting is essentially a balancing act: emphasizing one part of the health system or the health care experience may have negative and unanticipated impacts in other areas.

Even with the establishment of shared vision statements, strategic directions and priorities to help guide decision making, policy makers, planners, administrators and front-line health care professionals are challenged with persistent questions such as how to define quality, resource distribution, and how to go about designing and delivering programs that will actually achieve the vision and strategic directions.

In the fall of 2008 the Central East LHIN joined the Institute for Healthcare Improvement (IHI) prototyping initiative called the Triple Aim. For the past year and going forward, the Central East LHIN has benefited by working with other health care organizations from around the world in a learning environment that tests initiatives that are intended to achieve the "Triple Aim." At the present time, the Triple Aim approach is growing globally and in Ontario with all 14 LHINs committed to the approach in some capacity.

Figure 2: Design of a Triple Aim System Level Initiative



So what is the "Triple Aim?" In simple terms, the Triple Aim is the simultaneous pursuit of enhancements in population health (**PH**), patient experience (**E**) and value for money (**$**) by controlling or reducing the health care cost per capita. All this may appear easy, but experience shows that if not attended to, these aims can pull in different directions. For example, activities focused on improvements in patient experience may lead to either no benefit or negative outcomes in population health or value for money.

All too frequently health care systems worldwide find themselves providing more high cost health care services that provide little overall value to the patient experience and population. This is in part because health care financial incentives are often supply-driven, meaning the more care an agency provides, the more revenue is expected, regardless of the value or

outcome produced. In other instances, health care providers are not incented to get "up-stream" to provide lower cost options that prevent complications, resulting in higher-cost health care services. The end result is an unsustainable health system that provides more higher cost specialty services without demonstrated overall improvements in population health. More important than these costs to the health care system are the direct costs incurred by patients, family and communities.

Why the Triple Aim for the Central East LHIN?

In the Triple Aim model, the Central East LHIN found an explicit framework that succinctly captures the vision, strategic aims and mandate of the LHIN. It also found an execution framework that will significantly advance the realization of these aims.

Specifically, in the design and achievement of a Triple Aim system-level initiative, the model requires partnerships of health care and non-health care stakeholders, the use of system-level-metrics to help measure performance improvement, and the application of six steps or approaches (see Figure 2) that are outlined below:

Define Quality from the Perspective of the Patient Experience of a Defined Population

The starting point in applying a Triple Aim approach lies not in some abstract theory but in stories from patients. "Quality" is defined through a series of stories that make clear the perspectives of individual clients from a defined subset of population (e.g., Seniors that visit the emergency department, or Diabetics with a mental illness). Solutions are built around these stories and then tested for effectiveness and broader application to the targeted population. In the following sections of this IHSP, we share stories from patients in emergency departments or those with a vascular disease.

Patients and Families At the Forefront of System Design

The health care system should be oriented around the needs, preferences and strengths of patients and their families. This should include:

- providing information describing the system's performance on access, clinical effectiveness or quality, safety, and patient satisfaction
- establishing of coalitions of health and social service providers to meet the needs of medically and socially complex individuals
- including the patient and family in the customization of the plan of care
- learning from the patient experience to drive continued improvement
- supporting individuals and their caregivers to better manage their own health

Definition and Redesign of "primary health care" services

While much of the primary care delivery model is outside the scope of the Central East LHIN, we must actively support provincial and local initiatives to enhance multidisciplinary care, improve local access and broaden the primary health care services envelope.

System Integration and the Role of the Integrator

The requirement of system integration led by a system integrator further enforces the Triple Aim applicability to the LHIN mandate. In the words of the IHI, the system integrator, such as the Central East LHIN, is "an entity that accepts responsibility for all three components of the Triple Aim for a specified population." The integrator has the "important function of linking

organizations across the continuum … that can induce coordinative behavior among health service [providers] to work as a system for the defined population."

Cost control platform – per capita cost reduction

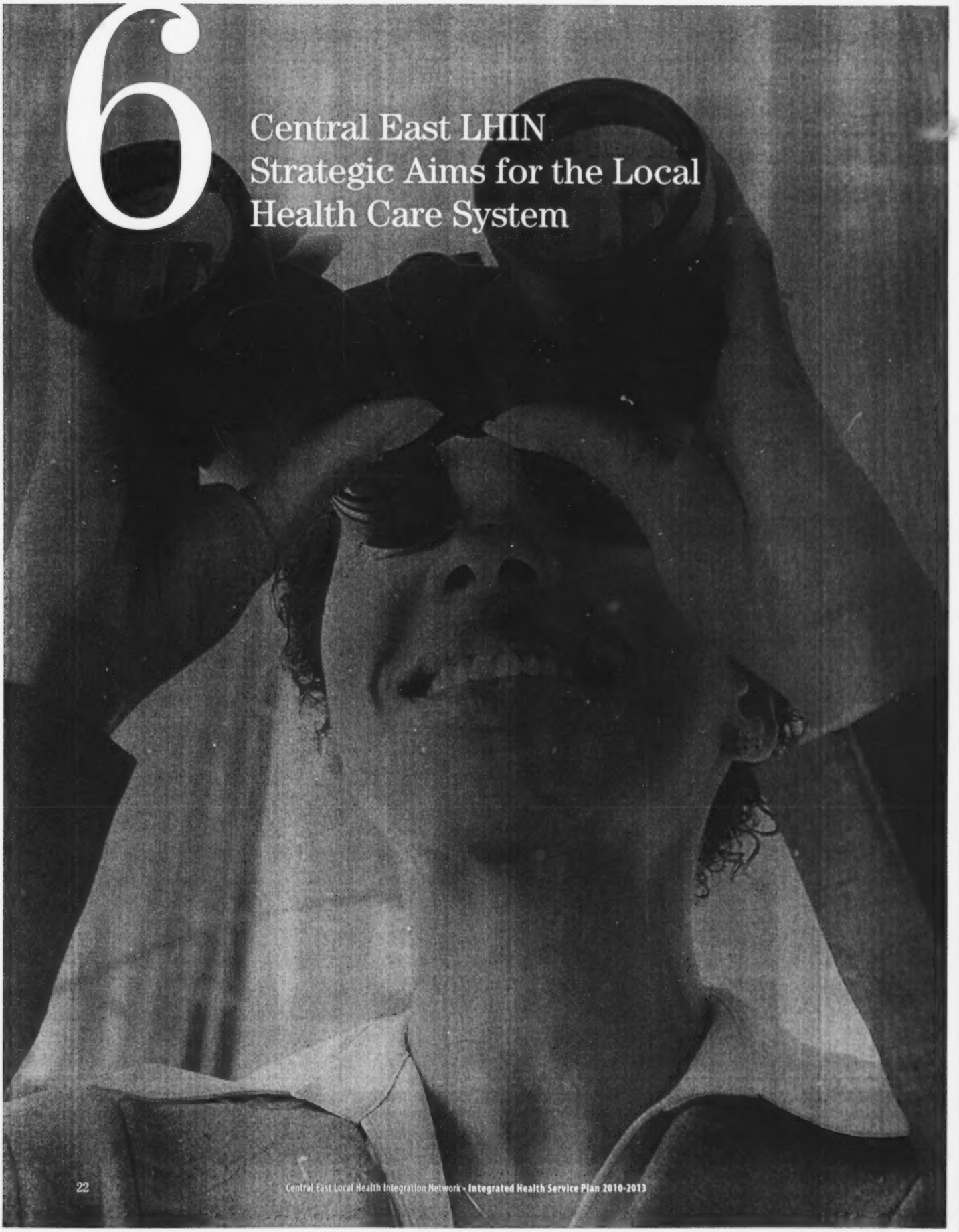
Given our economic realities we must not only strive to do more with less but make sure that what is funded generates tangible outcomes for the patient and the community. Savings must be identified that can be reinvested into health care improvements. To do this may require providing incentives to health care providers for producing better results and not just more health care. It also requires ongoing improvements to the patient journey so that health care and non-health care services are leveraged to create the best outcomes with the least cost.

Prevention and Health Promotion

Like primary care, public health is not within the Central East LHIN mandate. However, it is clear that our vision speaks to health promotion and disease prevention and management. To achieve this requires active partnerships with other health care and non-health care sectors to promote healthy lifestyle, reduction of substance abuse, and building capacity for self-management among patients and caregivers.

In the following Sections of this IHSP, we outline two major strategic aims that have been designed as Triple Aim system-level initiatives that will not only achieve the "Triple Aim," of better health, better patient experience and better value-for-money, but also the strategic priorities of the Ministry of Health and Long-Term Care and the Central East LHIN.

6 Central East LHIN Strategic Aims for the Local Health Care System



Central East LHIN Strategic Aims for the Local Health Care System

The 2010-13 IHSP is focused on two Triple Aim system-level initiatives or "strategic aims" that will propel the achievement of the vision and strategic directions of the Ministry of Health and Long-Term Care and the Central East LHIN.

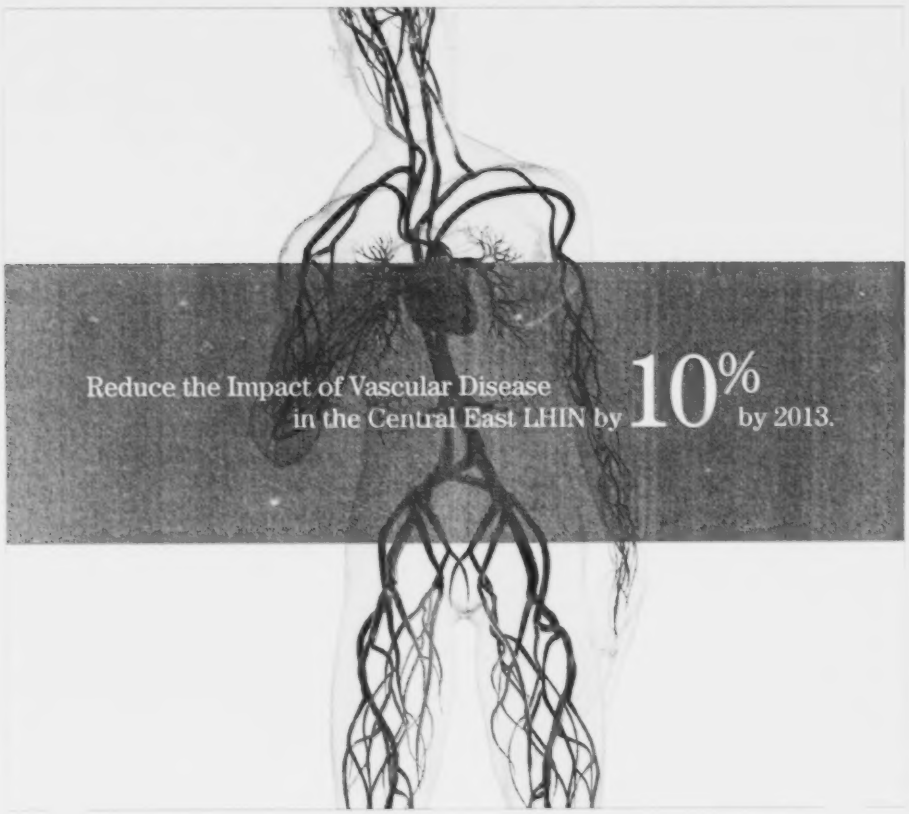
To provide greater clarity, demonstrate commitment, and build momentum for coalition-building between health care providers and non-health care providers, these initiatives or strategic aims are stated in plain language with specifics on the measures and timeframes for success.

Strategic Aim #1: *In support of the Ministry of Health and Long-Term Care's Strategic Priority to improve emergency department wait times and Alternate Level of Care, the Central East LHIN will*

Our strategic aim is to save one million hours of time patients spend in Central East LHIN Emergency Departments by 2013. This aim aligns with the Ministry of Health and Long-Term Care (MOHLTC) priority to decrease time patients spend in the emergency department. Saving 1,000,000 hours will be accomplished by reducing the number of visits to the emergency

departments (reducing emergency department demand), improving the flow within the emergency department (improving emergency department capacity and performance), and providing more appropriate levels of care in the community for patients who no longer require acute care services within the hospital, reducing ALC and improving bed utilization.

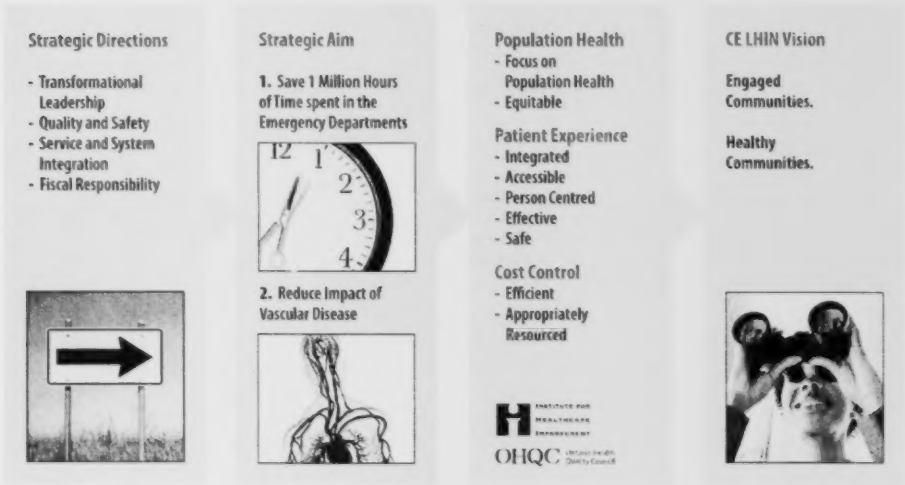
Strategic Aim #2: ***In support of the Ministry of Health and Long-Term Care's Strategic Priority of improving access to integrated diabetes care, and in recognition of the significant LHIN investments in chronic disease prevention, early detection, self-management and effective and equitable access to treatment such as stroke care, the Central East LHIN will***



Our strategic aim is to reduce the impact of vascular disease on individuals and the health care system in Central East LHIN by 10% by 2013. Reducing the risk of people developing *and* effectively and efficiently managing vascular disease will reduce the impact of vascular disease on individuals and the health care system. While success will be measured in terms of hospital patient days, success will require the collective effort of patients, health care clinicians, community-based agencies and hospitals.

With these two strategic aims articulated, and the Triple Aim framework for planning defined, we can now move to Step 2 of the Central East LHIN 2010-13 IHSP Strategy Map. **Figure 3** depicts how the two strategic aims will support the IHI Triple Aim and the Ontario Health Quality Council's attributes of a high performing health system. The achievement of these outcomes will move us closer to the realization of the Central East LHIN vision.

Figure 3: Step 2 of the Central East LHIN IHSP Strategy Map



Priority Populations

In keeping with the first IHSP, this second IHSP has identified segments of the population where it will prioritize its efforts:

Seniors...

- who are in the community at risk of hospitalization or becoming ALC
- who are in the hospital at risk of becoming ALC or of suffering an adverse event or functional decline during their stay
- requiring comprehensive community-based geriatric care, supportive housing, rehabilitation or other services to meet their complex needs
- requiring services and supports for their acute and chronic illness such as dementia and their caregivers

People with a Mental Illness and/or Addictions...

- who require primary care and community crisis support as an alternative to emergency department visits or hospitalization
- who are in the emergency department and require supportive access to hospital in-patient care, outpatient services, peer support and/or social services.

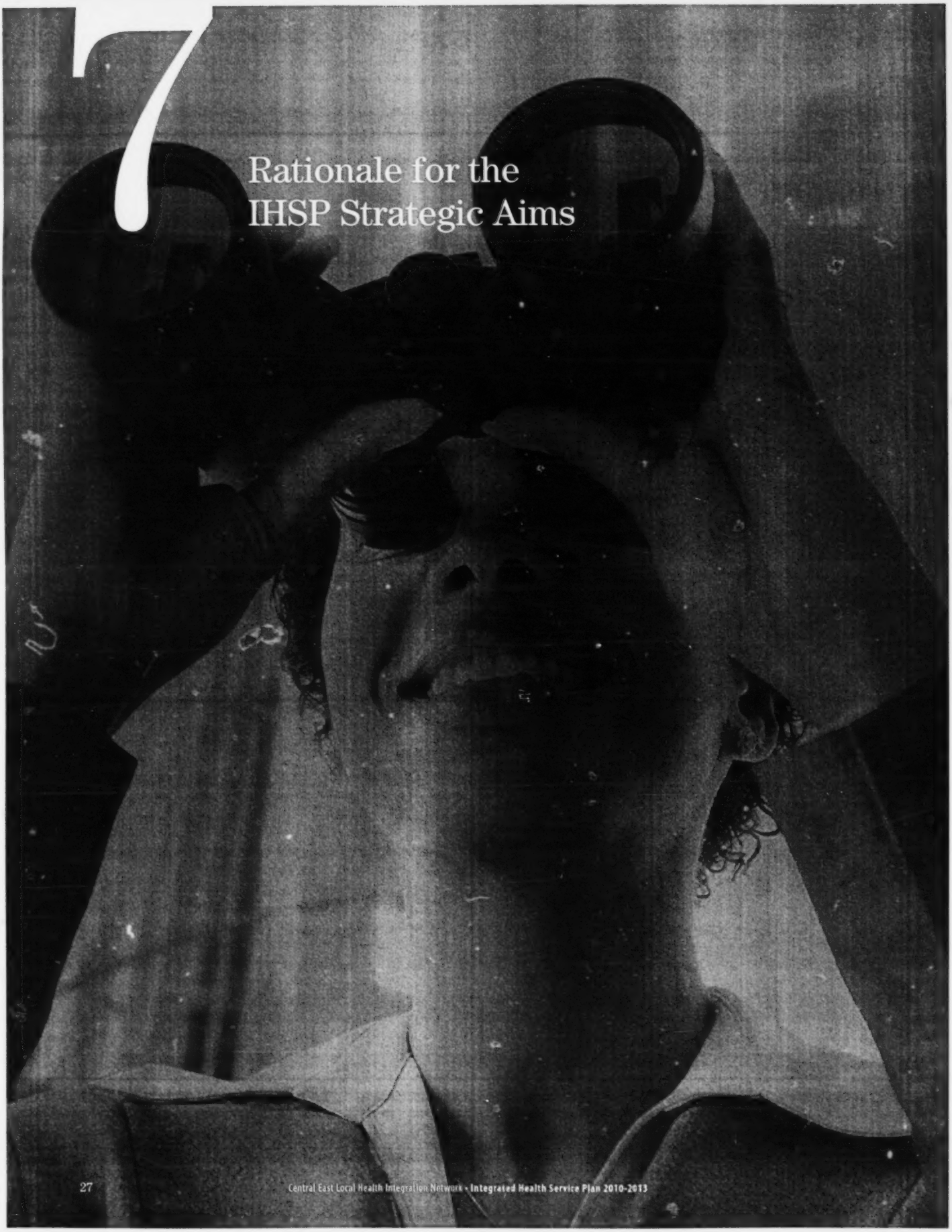
- who are at risk of developing a chronic disease or complications from their chronic conditions
  - 30% of people with diabetes are thought to also have a mental illness such as depression or anxiety, and people with anxiety are up to six times more likely to die of coronary heart disease[9]
  - further, many psychiatric medications tend to cause metabolic syndrome[10] and diseases such as diabetes
- require timely access to integrated community and/or hospital-based services

As per the *Local Health System Integration Act*, the Central East LHIN will continue to work with persons and organizations from the Francophone and First Nation, Metis and Inuit communities in the Central East LHIN. Through collaboration, the LHIN and these partners will also prioritize segments of their population that will support the equitable achievement of these aims for all.

9 UK Mental Health Foundation.

10 Metabolic syndrome is a combination of medical disorders that increase the risk of developing cardiovascular disease and diabetes [1] It affects one in five people, and prevalence increases with age

7 Rationale for the IHSP Strategic Aims



Rationale for the IHSP Strategic Aims

These strategic aims for the publicly funded health care system are based on the priorities of the government of Ontario. They are also consistent with what citizens and health care professionals have told the Central East LHIN is important to their own health care, and the health of their families and communities.

Confirming the IHSP Strategic Aims Through Community Engagement

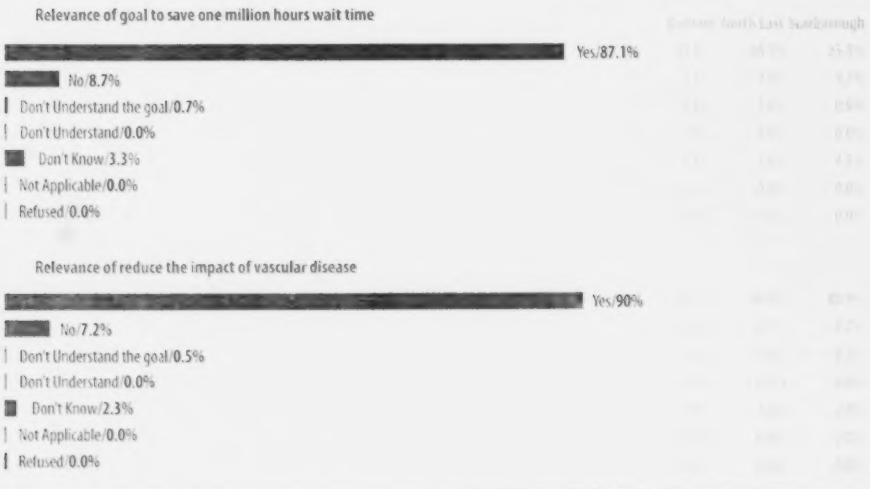
Unlike the first IHSP in which the LHIN spent significant time and effort travelling to each Central East community to meet with local residents and health care providers, the 2010-2013 IHSP builds on the experience, advice and direction given to the Central East LHIN through several defined channels of formal and informal community engagement.

With particular reference to the emergency department and vascular health aims, the Central East LHIN used its **Annual Planning Symposium** (Oshawa, May 14-15, 2009) to engage stakeholders on their ideas of how they could individually and collectively achieve simultaneous enhancements in population health, patient experience and value-for-money based on the Triple Aim Framework.

The LHIN then brought together local health care experts into two separate "think tank" **strategy sessions** – one for each aim – to help guide LHIN staff on how the system can achieve these Strategic Aims. These same experts were then provided with draft versions of the IHSP to get further feedback and direction.

In a new approach, the Central East LHIN initiated a public **telephone poll** to measure the local public's current level of confidence in the health care system, as well as to provide an

Relevance of LHIN's Aims



opportunity to shape and validate the two strategic aims. Over one thousand (1140) households were contacted by the health care research and marketing firm NRC Picker Canada and asked a series of questions related to hospital emergency departments and chronic conditions such as diabetes and stroke. Examples of responses to this poll are offered below, with the full report available on-line[11].

Rationale for the Strategic Aim to Save 1,000,000 Hours of Time Patients Spend in Central East LHIN Emergency Departments by 2013

What do we mean by time spent in the Emergency Department?

Patients spend a lot of time in a hospital emergency department whether waiting for services or being treated. The overall time a patient spends in an emergency department is from when they are registered to the time they physically leave an emergency department either by being discharged home or admitted into a hospital bed[12].

I cracked my ribs a few weeks ago racing go karts with my son. I knew they were cracked having had them cracked as a teenager playing football. I also knew there was nothing to be done really so I let it go. Yesterday I sneezed and almost passed out from the pain. I also wasn't sleeping and needed some prescription pain killers. So here were my choices. I don't have a family doctor – mine closed his practice three years ago – and my community has no doctors taking new patients. I could have gone to a walk-in but it would have taken two days to get results from an x-ray and a prescription. So I opted for the emergency department and brought a book. I didn't have a choice if I wanted my prescription last night. It took 6 hours to see the doctor and then 30 minutes from him seeing me to leaving with my prescription. Here's the question – why didn't they send me for an x-ray right away when I told them what had happened? Why did I have to see the doctor before they took the picture?

Time spent in an emergency department may include:

- registering and being evaluated for severity of condition (being 'triaged')
- waiting to see a clinician(s)
- being seen by a clinician(s)
- receiving diagnostic tests
- waiting for treatment or test results
- waiting for a hospital bed once admitted
- waiting for transfer to another facility or transportation home
- waiting for community support services to be arranged
- preparing for discharge home

11 The Central East LHIN also provided a web-enabled version of the telephone survey to the general public. The more than 230 responses received were consistent with the results of the telephone survey. However, these results have not been incorporated into the report as they would distort the validity and reliability of the telephone survey.

12 To see the flow of a patient visit to the ED, see the Emergency Department Process Map in the "Central East LHIN Emergency Department Task Group Report"(June 2008), Appendix A. http://www.centraleastlhin.on.ca/uploadedFiles/Home_Page/Be_Informed/ED_report_FINAL_June%202008.pdf

Time spent in the emergency department is too long.[1] Although some of this time is necessary, particularly for sicker or more seriously injured patients, much of it is not. More time spent in the emergency department is a nuisance for patients with less urgent needs, and decreases access to care for patients who need faster and more dedicated treatment.

[1] Ministry of Health and Long-Term Care ED/ALC Quarterly Stocktake Report

Why is saving time spent by patients in emergency departments important?

Saving time spent by patients in Central East LHIN emergency departments will result in increased access to services, decreased cost to the individual and to the health care system, improved efficiency and effectiveness, and increased patient satisfaction.

- Approximately 40% of emergency department visits are made by patients with non-urgent or less urgent needs[13]
- 90% of patients across the province are treated within 9.4 hours from registration/triage to discharge, longer than the provincial length of stay guidelines for any patient category[14]
- Time patients spend in the ED is approximately five times longer for patients admitted to hospital than for non-admitted patients[15]

Size and Scope of Time Spent in an Emergency Department

Central East LHIN residents spent approximately 2.5 million hours in hospital emergency departments across the LHIN in 2008/09. In order to know what this number means, it is important to understand how emergency departments work.

Anyone coming into an emergency department is evaluated by a medical professional to determine the urgency of his or her condition. This evaluation is called "triage," which means "sorting," and in Canada, the standard scale for this sorting is the Canadian Triage and Acuity Scale, or CTAS. CTAS levels are defined such that level I represents the sickest patients and level V represents the least ill group of patients. Explanation and examples of cases which would fall under each CTAS level are listed below.

CTAS Level	Condition
I. Resuscitation	Threats to life or limb requiring immediate aggressive interventions, such as cardiac or respiratory arrest, unconsciousness or major injury.
II. Emergent	Potential threats to life, limb or function, requiring rapid medical intervention, such as heart attack, stroke, head injury or overdose.
III. Urgent	Conditions that could potentially progress to a serious problem, such as moderate injury, asthma, suicidal thoughts or acute pain.
IV. Less Urgent	Conditions related to patient age, distress, or potential for deterioration or complications, such as headache or chronic pain.
V. Non Urgent	Acute but non-urgent conditions or those which may be part of a chronic problem, such as sore throat, colds, vomiting or diarrhea.

13 MOHLC Emergency Department Reporting System (EDRS) 2008-09
14 Ministry of Health and Long-Term Care ED/ALC Quarterly Stocktake Report, July 2009
15 EDRS 2008-09

CTAS I and II patients often require more services and take more time to treat, because they are more ill. This is also true of patients who are admitted to the hospital regardless of the CTAS level at which they were initially assessed.

On average Central East LHIN residents spend longer in an emergency department than the provincial guidelines for patient length of stay in an emergency department. Of all 14 LHINs, the Central East LHIN has the 5th highest average emergency department length of stay.

MOHLTC Length of Stay Guidelines

Patient category	ED Length of Stay Guidelines
Admitted patients	≤ 8 hours
Non-Admitted CTAS I-II patients	≤ 8 hours
Non-Admitted CTAS III patients	≤ 6 hours
Non-Admitted CTAS IV-V patients	≤ 4 hours

The goal for all hospitals in the province is for 90% of all patients to be treated within these guidelines. In 2008-09, in the Central East LHIN, the average patient length of stay for different CTAS levels is indicated below:

Central East Emergency Department Visits by Patient Category (2008/09)

Category	Percent of Central East LHIN visits(%)	Average Length of Stay(Hours)	Percent treated within guidelines
Admitted Patients	10%	18.7	33%
Non-Admitted Patients (CTAS I-II)	11%	4.9	86%
Non-Admitted Patients (CTAS III)	37%	4.1	82%
Non-Admitted Patients (CTAS IV-V)	42%	2.6	82%

Why People Choose to Use an Emergency Department

There are many reasons for emergency department visits. People often use an emergency department as a way of dealing with health concerns that they believe cannot be dealt with in other ways. In the Central East LHIN, we know that people are coming to an emergency department for more than urgent and/or critical needs. While the reasons are highly individualized, our information shows the following reasons for emergency department visits:

- people sometimes don't know where to go for their care (e.g., emergency department vs. primary health care provider),
- people don't know what other appropriate options exist (i.e., urgent care clinic, walk-in clinic),

- an emergency department becomes the alternative for people without primary care providers (approximately 86,000 individuals in the Central East) and for those who cannot get a timely appointment; or,
- people often believe that their health situation is critical in nature and cannot be addressed in other settings.

My daughter came down with symptoms of an ear infection on a Tuesday. By Thursday we knew she needed a doctor. Our family doctor couldn't see us for 10 days. They suggested an after hours clinic but all the available appointments were booked. On Monday night she woke up several times crying so at 3 a.m. we got up and drove to the emergency department. They were very understanding when we apologized that we had tried to see our family doctor or the after hours clinic. She was given antibiotics and pain killers. We were very grateful to get this treatment but felt badly that we had to use the services of our hospital for something relatively minor.

Main reasons for visiting Central East LHIN Emergency Departments

Below is a list of the top 5 reasons people visited an emergency department in the Central East LHIN in 2008/09.

CE LHIN Telephone Poll - August 2009
(multiple responses possible)

"What prompted your last visit to the ED?"

-Didn't know where else to go.....28%
-No other options available..... 59%

Main Problem Group	Central East		Ontario	
	#	%	#	%
Injury, poisoning & other consequences of external causes	137,035	25.9	1,283,291	24.2
Symptoms, signs & abnormal clinical & laboratory findings	108,352	20.5	1,074,304	20.2
Diseases of the respiratory system	53,119	10.1	563,678	10.6
Diseases of the digestive system	35,750	6.8	333,128	6.3
Diseases of the musculoskeletal system & connective tissue	31,017	5.9	329,138	6.2

Alternate Levels of Care and Emergency Department Performance

Improving bed utilization speeds up the movement of patients through the hospital and maximizes hospital capacity[16]. Among the drivers of bed utilization is the goal of making the best use of the length of time patients spend in acute care beds based on standard of care practices for their condition. As well, hospitals must balance the appropriate distribution of bed types with the care needs of the patient population to ensure the right care in the right place at the right time. These are important efforts that will continue to be supported over the next three years. However, the perceived lack of hospital beds is often attributed to the number of patients designated as "Alternate Level of Care" or ALC.

16 Ministry of Health and Long-Term Care ED/ALC Quarterly Stocktake Report, July 2009

The ALC designation is defined by the province as anyone occupying a bed in a hospital who does not require the intensity of resources/services provided in that care setting.

These patients are occupying hospital beds while waiting for transfer to other hospital units or discharge to any number of destinations including long term care, rehabilitation services, and home. In 08/09, the Central East LHIN had 15.26% ALC days[17] and the provincial goal for 2009/10 is 9.46%.

Tables describing the extent of the ALC issue categorized by main diagnosis and hospital can be found in the CE LHIN Environmental Scan.[18]

Rationale for the Strategic Aim to Reduce the Impact of Vascular Disease by 10% by 2013

What is Vascular Disease?

Vascular disease is more than just a heart attack. Vascular diseases are a broad group of health conditions that affect almost all parts of the body – from head to toe. Vascular disease includes cardiovascular (heart), cerebrovascular (brain) including vascular dementia and stroke, and peripheral vascular disease which presents in other areas of the body such as kidneys, arms and legs. Vascular disease impacts our individual health and our health care system.

My brother-in-law died from a massive heart attack two months ago. He was in his early fifties and was just about to celebrate his twenty-fifth anniversary with my sister. Instead he died in her arms in the living room. We all thought he was healthy, but turns out that over the years plaque had been building up in his arteries and it had ruptured. They say he had a disease called atherosclerosis that could have been easily detected and treated. No one knew. Now everyone in the family is watching their diets, exercising a little more and booking regular checkups. I never really thought about vascular disease before but we all have a responsibility to take care of ourselves and the ones we love.

Vascular disease is characterized in our bodies by a thickening or narrowing of the arteries that move blood through our bodies. It is this thickening or build-up inside arteries (*arthero-sclerosis*) that is commonly referred to as 'hardening of the arteries'. Vascular disease can damage eyes and cause blindness, restrict blood flow to the brain resulting in memory-loss (dementia) or stroke, cause heart attacks or heart failure, raise blood pressure, impair kidney function, and cause swelling or inflammation in arms and legs (peripheral vascular disease) which can lead to tissue loss (gangrene, wounds) and possible limb amputation.

The Continuum of Chronic Disease Care

1. prevention and primary health care
2. pre-hospital and ambulatory care
3. acute care
4. secondary prevention of disease progression/adverse events including rehabilitation care
5. palliative/end of life care

17 ALC days as a percentage of total inpatient days
18 http://www.centraleastlhin.on.ca/uploadedFiles/Home_Page/Be_Informed/CEe-HealthStratPlan2007.pdf

Why is reducing the impact of vascular disease important to the health care system?

Vascular diseases are major causes of illness, disability, hospitalization and death in the Central East LHIN and across Canada. Despite reductions in the number of people who die each year from vascular diseases it remains the number one threat to the health of Canadians. Vascular disease is prevalent in the Central East LHIN, results in high numbers of hospital admissions and emergency department visits and is costly to individuals and the health care system. In 2000 it was estimated that direct health care and related indirect costs for vascular disease in Canada was $22.2 billion; this cost was second only to musculoskeletal disease.

Complications due specifically to vascular disease – such as stroke or heart attacks – tend to result in higher hospital utilization. In 2008-09 in Central East LHIN hospitals:

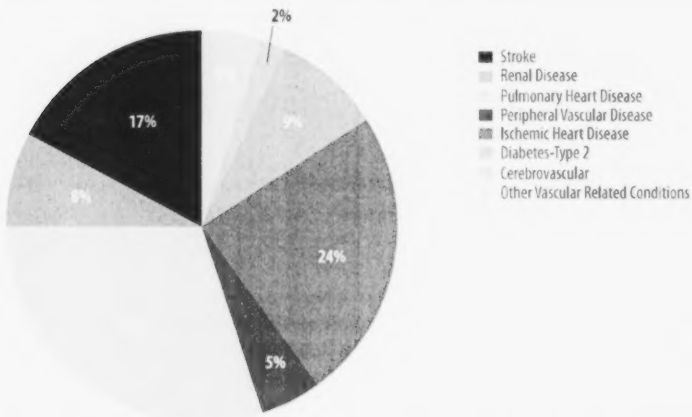
- 26% (25,100) of inpatient discharges were attributable to chronic diseases, more specifically 8,550 of inpatient discharges were a result of heart disease[19]
- Almost 31% (25,485) of Alternate Level of Care (ALC) days were attributable to chronic disease, with 6,248 days attributable to stroke
- In critical care, 5,354 (46%) cases were related to chronic disease, with 3,297 (62%) related to heart disease
- 35,204 (6.7%) emergency department visits were related to chronic disease, with 26,491 attributable to arthritis and related conditions
- In 2007, hypertension and diabetes were the two top reasons for visits to primary care providers

Vascular-Related Medical Conditions reported for CE LHIN Residents (Adults)	Total Patient Volumes in ALL Day Hospitals*	%
Cerebrovascular	2,525	2%
Diabetes-Type 2	12,917	9%
Ischemic Heart Disease	32,291	24%
Peripheral Vascular Disease	7,184	5%
Pulmonary Heart Disease	40,854	30%
Renal Disease	10,505	8%
Stroke	23,596	17%
Other Vascular Related Conditions	6,748	5%
Total	**136,620**	**100%**

**This table represents the total vascular related hospital days for Central East LHIN residents, including days spent in hospitals outside of the Central East LHIN. 72.7% of Total patient days reported for Adult Central East LHIN residents (>=15 years) were treated within Central East LHIN, with 21.3% receiving treatment in Toronto Central LHIN.*

19 Includes heart disease, ischemic heart disease and pulmonary heart disease.

% Breakdown of all Vascular-Related Conditions Total Patient Days



Nine out of every ten Canadians over age 20 have at least one risk factor for vascular disease and one in three have more than one risk factor (Public Health Agency of Canada 2009). The face of vascular disease is now younger, increasingly female, ethnically diverse and frequently Aboriginal or South Asian (CHHS 2009).

With specific reference to the impact of diabetes on the health care system, it is important to note the majority of illness (morbidity) and death (mortality) amongst people with diabetes are a result of vascular disease complications, including coronary, peripheral and cerebral arterial disease. According to the Canadian Community Health Survey of 2007, the Central East LHIN has the highest prevalence rate of diabetes in Ontario at 8.9% for youth and adults.

It is estimated that supporting one person with Diabetes to control their blood glucose (A1C) when it was not controlled before, will avoid:

- 1 in every 109 Heart Attacks (Acute Myocardial Infarctions [AMIs]),
- 1 in every 111 foot amputations,
- and prevent 1 in every 343 deaths.

Similarly, reducing the blood pressure of one person who had diabetes and coronary artery disease (CAD) to the recommended level of 130/80 will avoid:

- 1 in every 169 heart attacks,
- 1 of every 1250 amputations,
- 1 in every 238 strokes,
- and prevent 1 in every 224 deaths.[20]

20 Number Needed to Treat Table, Ontario Health Quality Council 2009

Cost savings to the health care system resulting from getting one diabetic's A1C under control is 1 of every 109 heart attacks at a cost of $7331 per heart attack, plus 1 of every 111 amputations at a cost of $24,480 per amputation.[21] If we were to add to this other related health care costs, such as repeat emergency department visits, in-home nursing/wound care, rehabilitation, community support services, the cost savings would be even greater.

Determining the true cost of illness and disability to the individual and the health care system includes more than just physician support, hospital staff, medications, equipment, operations and supplies. It also includes work time/wages lost, travel/parking, childcare/respite, emergency transportation, in-home care, and rehabilitation.

Like many women my best friend didn't pay attention to the various aches and pains she had on a daily basis. She hadn't been to her family doctor in about five years and just took over the counter medication for her on-going headaches. One day she went to a blood pressure clinic in the mall. Her blood pressure was through the roof and they sent her to the Emergency Department right away. Turned out that after a whole series of tests they found out that she had early renal impairment that was impacting her kidneys. Now she takes the right medication and has regular checkups. You know, she could have died.

How Are We Doing in the Fight Against Vascular Disease?

Prevalence of Vascular Disease in the Central East LHIN

Prevalence is the proportion of our population with any given disease or condition at a given moment in time. As such, prevalence provides us with a broad system level measure of disease burden. Measuring the change in prevalence of vascular conditions and associated modifiable risk factors provides a high level population or system-level measure of how we are doing toward achieving our aim of reducing the impact of vascular disease by 10% by 2013.

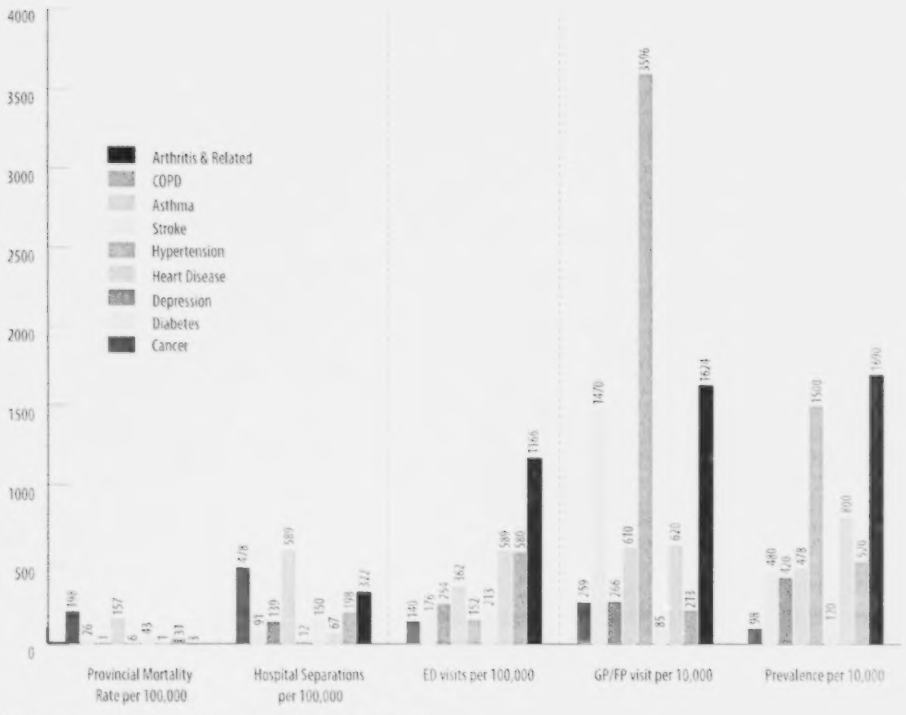
In 2006, 36% of Central East LHIN residents over age 12 (approximately 438,000 people) reported having one of the following chronic health conditions: cancer, diabetes, heart disease, hypertension, stroke, asthma, COPD or arthritis. Of these individuals, over 1/3 had more than one chronic condition (co-morbid conditions). It was found that almost half of individuals aged 65 years or older had reported having two or more of these conditions.

21 Ontario Case Costing Initiative

In a recent telephone poll of Central East LHIN households, 67.9% identified that someone had high blood pressure and 58.4% that identified someone had high cholesterol.

The Canadian Community Health Survey (CCHS) identifies change in the *prevalence of chronic conditions and modifiable risk factors* in our LHIN and across Ontario. As of 2007 the CCHS is completed annually, thus prevalence data will be available on a more frequent basis.

Comparative Burden of Chronic Conditions in the Central East LHIN



Source: Canadian Community Health Survey (CCHS), MOHLTC Provincial Health Planning Database (PHPDB)

Modifiable Risk Factors for Vascular Disease in the Central East LHIN

Did you know?

- 19.4% of people age 12+ in the Central East LHIN have **high blood pressure**. This is the third highest rate in the province. 9 out of 10 Canadians will develop high blood pressure in their lifetimes.
- 34.7% of people in Central East LHIN age 12 and older are **overweight** while 14.4% are obese.
- 18.5% of persons age 12 and older in the Central East LHIN **smoke** – similar to the national rate. Alarmingly 15% of youth in Canada aged 15-19 smoke.
- 52.9% of people age 12 and older are **physically inactive** - the third highest LHIN in the province for prevalence of physical inactivity.
- 57.3% of people age 12 and older in Central East LHIN **eat less than five servings of fruits or vegetables** per day
- 85% of men and 60% of women in Canada age 19-70 have **sodium** intakes exceeding recommended limits.

How does reducing the impact of Vascular Disease link with the Ministry of Health and Long-Term Care Priorities?

Focusing on reducing the impact of vascular disease in Central East LHIN will contribute to the achievement of the Ministry of Health and Long-term Care's priorities of reducing emergency department wait-times, reducing the number of days that patients spent waiting in hospital for an alternate, more appropriate care setting (ALC days) and improving access to integrated care for diabetics.

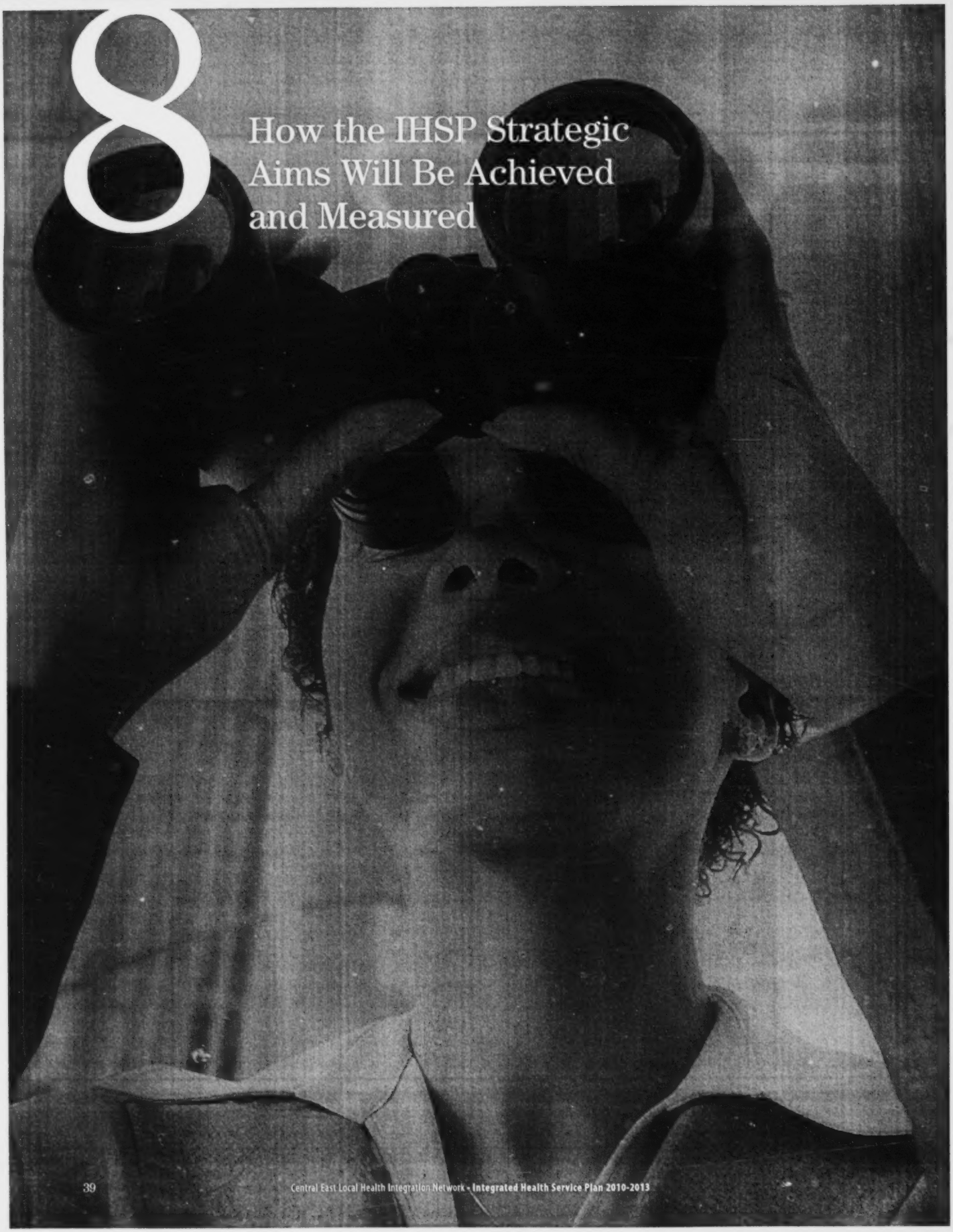
In Central East LHIN, *integrated diabetes care* is defined as care delivery that:

- is integrated between primary care and specialty care (e.g. specialists, Diabetes Education Centres);
- considers the needs of the whole person including their multiple chronic conditions and social support; and,
- is a system which is coordinated within and across the three geographic clusters of Scarborough, Durham and the North East.

Strategies to reduce the impact of vascular disease will provide integrated care for people with diabetes and other chronic conditions and will positively affect hospital activity.

Given the common prevalence of diabetes with other vascular chronic conditions, the Central East LHIN sees the inclusion of diabetes within a broader vascular health strategy as an effective and efficient means for deploying primary health care initiatives, disease management and self-management programs. This broader approach is expected to positively affect other LHIN-funded health care services such as cardiac care, chronic kidney or renal disease, dementia programs and stroke services.

8 How the IHSP Strategic Aims Will Be Achieved and Measured



How the IHSP Strategic Aims Will Be Achieved and Measured

This section outlines the known specific initiatives or actions that have been or will be initiated by the LHIN and local health care providers in order to realize the Ministry of Health and Long-Term Care priorities and LHIN strategic aims as stated in this IHSP. This section also provides suggestions on what health care providers, social service partners and individuals can do to help us achieve these aims.

Resourcing the Achievement of the Strategic Aims

To assist in the achievement of these strategic aims, the Central East LHIN will use funding resources made available by the government of Ontario. These resources are tied to specific strategies of the LHIN and Ministry of Health and Long-Term Care including:

- The Aging at Home Strategy
- Emergency Department Pay for Results Program
- CE LHIN Urgent Priority Funding
- eHealth Funding
- Other funding provided by the Ministry through the Diabetes Strategy

While important, the achievement of our system strategic aims requires more than just funding. It requires leadership and innovation on behalf of all parts of the health care system to search for ways in which they can contribute directly or indirectly to the achievement of the strategic aims, whether this is within their own organization or in partnership with others.

In addition to acting as the integrator of the health care system, the Central East LHIN will support health service providers and other organizations to achieve these aims through:

- providing opportunities for learning and knowledge exchange across sectors and regions through community engagement, planning partners, working groups and project teams;
- supporting initiatives with evidenced-based data and information;
- fostering coalitions among organizations at all levels (governance, management and front-line care);
- continuing the uptake of Project Management skills by health care providers through the training and tools made available through the Central East LHIN Project Management Office; and,[22]
- supporting integration activity through service and financial planning, integration toolkits and expertise.

An Execution Strategy

Another way in which the Central East LHIN will support the achievement of these strategic aims is through the application of an effective execution strategy both internal to the LHIN and to external partnerships. It is important to note that no one project will achieve the aims of the Central East LHIN. Rather, success will require the deployment of multiple projects, tailored to meet the needs of specific population segments and health service provider capacity. The IHI Triple Aim not only provides a framework for system design, but also

22 http://www.centraleastlhin.on.ca/report_display.aspx?id=7804

an execution strategy that the Central East LHIN has begun to implement. In this model, successful execution of our aims requires:

- designing a structure to support improvement (e.g. apply Project Management approaches and tools as supported by the Central East LHIN PMO);
- creating and supporting coalitions of health service providers and other agencies focused on the achievement of the strategic aims;
- developing a rational portfolio of projects to support the strategic aims;
- deploying resources to the projects (e.g., funding, tools, knowledge);
- executing each of the individual projects in the portfolio; and,
- providing oversight, learning, and integration.

How We Will Achieve and Measure Strategic Aim #1: Save 1,000,000 Hours of Time Patients Spend in Central East LHIN Emergency Departments by 2013.

Emergency Department Pay-for-Results

Pay-for-Results is a provincially funded, LHIN-led program that targets emergency department length of stay by funding hospitals and community agencies to implement programs or operational improvements. If length of stay targets are met in each of the six designated emergency departments in 2009/10, there will be an approximate overall savings of 442,000 hours of emergency department time in the Central East LHIN.

The Central East LHIN views emergency department time in the context of the larger health care system, and is committed to system-wide improvement. Therefore, to save 1,000,000 hours of patient time, the Central East LHIN has organized its focus into three strategies which mirror those of the Ministry of Health and Long-Term Care:

1. Reduce emergency department demand
2. Improve emergency department capacity and performance
3. Improve hospital bed utilization (e.g., ALC)

Central East LHIN Telephone Poll - August 2009 (multiple responses possible)

"How could the most recent emergency department visit have been avoided?"

Knowing other options of where to go.....81%

Being more informed about my health condition.....39%

Reduce Emergency Department Demand

Emergency department visits by patients with non-urgent or less urgent needs (CTAS IV-V) are sometimes referred to as "avoidable visits," where the type and level of care required by the patient could have been delayed or even referred to other areas of the health care system. Reducing the number of avoidable cases that present at an emergency department will enable emergency clinicians to provide faster and higher-quality care to unavoidable cases. Overall, Central East LHIN residents will spend less time in an emergency department because patients that can appropriately avoid emergency department-level care will be treated outside of the hospital.

The intent of these initiatives is to ensure that emergency department resources are available in a timely manner, and to provide appropriate care in other settings. There are many current initiatives underway addressing the three strategies and many more are anticipated.

Reduce Emergency Department Demand

Partners

Hospitals / Long-Term Care Homes / Community Care Access Centre / Community Based Mental Health and Addictions Providers / Supportive Housing Providers / Community Support Service Agencies / Police Services / Primary Health Care Providers / Community Health Centres / Urgent Care Centres / Individuals, Families and Caregivers

Strategies

- providing housing and care alternatives outside of the hospital setting
- enhancing access to primary care
- preventing, identifying, assessing, treating and managing health conditions in other settings
- increasing awareness and use of health care services available in the community
- increasing the capacity of community agencies and support services
- enabling patients to manage their own chronic conditions

Projects

- Community Crisis Supports for Mental Health Clients
- Supportive Housing Services for at-risk individuals
- Supporting Ministry expansion of primary care models and urgent care
- Nurse-Practitioners to Long-Term Care
- Community-based Comprehensive Geriatric Assessment
- Self-Management Resources
- Resource-matching and education to help clients locate alternatives to care
- Others as identified

Performance Indicator

- Rates of Emergency Department Visits per 1000 population
- Rate of Emergency Department Visits that could be Managed Elsewhere
- # of wait time hours saved/diverted from the emergency department

The Central East LHIN Emergency Department Avoidance Coalition includes hospital and community providers, including community mental health crisis services. Through the development of this coalition, health service providers were able to successfully manage a mental health client who had visited a hospital emergency department 83 times in a five month period. This client was supported throughout reintegration into the community.

Improving Emergency Department Capacity and Performance

Initiatives that increase emergency department capacity and performance will contribute to saving one million hours of emergency department time by helping move patients efficiently through the hospital. "Improving triage and admission processes and reducing ambulance offload times will improve the flow and capacity within the emergency department and enable emergency clinicians to provide more efficient care."[23]

From April 2008 through March of 2009, patients in the CE LHIN spent approximately 2.6 million hours in the emergency department, of which over 650,000 were spent by CTAS IV and V patients.

Improving Emergency Department Capacity and Performance

Partners

Hospitals / Community Care Access Centre / Emergency Management Services / Mental Health Crisis Teams / eHealth

Strategies

- Emergency department capacity and performance initiatives are hospital based and tend to address administrative and clinical practices such as:
  - Improving patient flow and improving efficiency of care practices
  - Adding equipment
  - Improving access to diagnostics
  - Using ancillary support/personnel
  - Utilizing eHealth to improve patient flow and referral

Projects

- Geriatric Emergency Management Nurses in the emergency department
- Process improvement programs such as LEAN methodology and the Flo Collaborative
- CCAC Case Management in the emergency department
- Rapid Assessment Units and Clinical Decision Units
- Additional health human resources through the Pay For Results program
- Triage and Assessment and crisis support to mental health clients in the emergency department
- eHealth projects such as ED Patient Self-Registration Kiosk, ED/CCAC Client Notification and Drug Profile View
- Others as identified

Performance Indicator

- Proportion of admitted patients treated within the LOS target of <= 8 hours [MLAA]
- Proportion of non-admitted high acuity (CTAS I-III) patients treated within their respective targets of <= 8 hours for CTAS I-II and <= 6 hours for CTAS III [MLAA]
- Proportion of non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of <= 4 hours [MLAA]
- # of emergency department wait time hours saved (resulting from the achievement of the above targets)

"We are committed to LEAN as our standard, enterprise-wide management philosophy and more than simply a process improvement technique. Transformation is occurring throughout our organization. 41 of 44 departments in the hospital have been involved in LEAN activities." (CE LHIN hospital, August 2009)

23 Ministry of Health and Long-Term Care ED/ALC Quarterly Stocktake Report , July 2009

Improving Hospital Bed Utilization

Improving bed utilization expedites the movement of patients through the hospital and maximizes hospital capacity.

Improving Hospital Bed Utilization

Partners

Hospitals / Community Care Access Centre / Emergency Management Services / Mental Health Crisis Teams / eHealth

Strategies

- Optimizing the length of time patients spend in acute care beds based on standard of care practices for their condition
- Appropriate distribution of bed types and services within and between hospital providers based on the needs of the patient population to ensure the right care in the right place at the right time
- Reducing ALC by providing community supports and placement alternatives based on population need
- Using eHealth to improve patient flow and referral

Projects

- Implementing the "one acute care network" plan to improve access to specialty services between hospitals
- Providing supportive housing services as alternatives to Long-Term Care
- Providing transitional care options outside of the hospital
- Promoting and supporting senior friendly hospital initiatives such as patient activation
- Improving discharge planning coordination between hospital and community services, such as "Home First"
- Supporting transportation initiatives to support movement to home and to other care providers
- Customizing care plans to support safe transitions in care (e.g., Wrap-Around Services for Seniors)
- Using eHealth solutions to improve patient discharge, notification of patient primary care team, resource matching and referral to expedite movement of clients to the next destination of care
- Others as identified

Performance Indicator

- Percentage of Alternate Level of Care (ALC) Days [MLAA]
- Patient experience (tbd)
- Hospitalization Rate for Ambulatory Care Sensitive Conditions (ACSC)

How Will We Measure Success for the Emergency Department Aim?

Success will be measured according to the government's emergency department wait time targets. These targets have been included as performance measures in the Ministry-LHIN Accountability Agreements:

1. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution
2. Proportion of admitted patients treated within the LOS target of <= 8 hours
3. Proportion of non-admitted high acuity (CTAS I-III) patients treated within their respective targets of <= 8 hours for CTAS I-II and <= 6 hours for CTAS III
4. Proportion of non-admitted low acuity (CTAS IV & V) patients treated within the LOS target of <= 4 hours

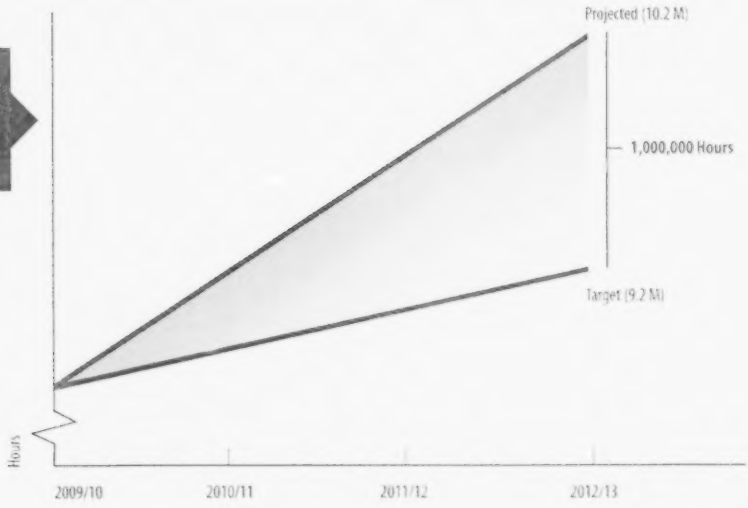
In an effort to summarize these specific targets, the Central East LHIN has established the aim of saving 1,000,000 hours of time patients spend in the emergency departments. This was done for several reasons:

- The aim motivates the entire health care system to mobilize its energy and participate in the strategy. While time spent in an emergency department is experienced in the hospital, many other parts of the health care system can contribute directly and indirectly
- The aim provides a clear and understandable commitment to all health care stakeholders
- The aim is expressed in real terms, and encourages front-line staff to make a direct contribution in number of hours saved
- Reducing time spent in an emergency department without addressing emergency department demand may create a perverse outcome in that an emergency department is seen as an alternative to more appropriate and cost-effective community and primary care alternatives
- The aim is expressed and measured in terms consistent with the Triple Aim – improving the health of the population, the patient experience of care, and value-for-money.

To measure our aim of saving one million hours of time patients spend in Central East LHIN emergency departments by 2013, we projected the number of hours that would have been spent in emergency departments between April 1, 2009 and March 31, 2013 if current trends continued. Using the baseline number of hours from the 2008-09 fiscal year, and accounting for demographic projections for the LHIN over a four year time period, we project that there would have been a total of approximately 10.2 million hours spent in Central East LHIN Emergency Departments. We then subtracted 1,000,000 from this number and arrived at 9.2 million, our target number of hours.

Measuring Our Aim – Save 1,000,000 Hours of Time Patients Spend in Central East LHIN Emergency Departments by 2013

By March 31 2013, to reach our aim, we must not exceed 9,206,454 hours spent in the emergency departments.



We will re-evaluate the projected number each year as actual information becomes available on population changes and other external factors. Any substantial changes to the information that informed the initial calculation of the target number will be incorporated, and so the actual target number may shift over the four-year measurement period.

How We Will Achieve and Measure Strategic Aim #2: Reduce the Impact of Vascular Disease in the Central East LHIN by 10% by 2013.

Our genes, physical and social environments and daily lifestyle choices (behaviours) all contribute to reducing or increasing our risk of developing vascular disease. Knowing genetic risk factors, and acting on modifiable ones will contribute to reducing the impact of vascular disease; but knowing and addressing risk factors is not enough.

Effective and efficient management (treatment) of vascular disease by individuals and health care providers is also needed. The ability to identify vascular disease at an early stage, slow the progression of the disease, avoid health complications, treat acute health events, and provide support to recover (convalescence or rehabilitation) all contribute to reducing the impact of vascular disease.

Increasing awareness and reducing exposure to risk factors, early identification and effective management (treatment) that supports self-management by individuals and their family/friend caregivers will improve health of people, the cost of health care and improve the experience of patients and caregivers in receiving care.

Take Action along the Health care Continuum in Community and Hospital Settings

The continuum of vascular health care is similar to that of other chronic conditions. Care and support happen at home, in the community and in hospital. In many instances, if care is not effectively and efficiently managed outside the hospital, complications and disease progression will result in care being provided in the hospital. Individuals, families, friends and health care providers play important roles at all points in this continuum. Opportunities to reduce the impact of vascular disease exist at each part of this continuum and at various levels; from improved client health outcomes to lowering the cost of delivering care and reducing wait-times for service. Reducing impact is not limited to the prevention end of the continuum.

Set and Pursue 'Ground-level Goals' for Improvement

Individuals, caregivers, clinicians and health service provider agencies must individually and collectively set and implement personal, agency or clinic/practice level strategies to contribute to reducing the impact of vascular disease.

Suggestions for Ground Level Goals:

- Screen an additional 10% of clients for vascular disease and its risk factors within 6 months
- Increase the number of patients participating in cardiopulmonary rehabilitation or physical activities by 10% in the next year
- Improve blood sugar (glucose) levels by 10% within 9 months for 10% of clients

Improve Patient Health Outcomes: Early Identification and Treatment to Best Practice Target

Optimal health outcomes can be achieved by patients and clinicians identifying and actively managing toward best practice targets for the following indicators:

- blood pressure, blood lipids, blood glucose, kidney function [i.e. biophysical targets]
- physical activity, healthy eating and tobacco use [i.e. behavioural goals]

Improvements in personal health outcomes and more effective use of health care services will be achieved by supporting people to identify their condition and risk factors; understand their optimal health targets; define realistic health goals and then to enable individuals to work in partnership with their health care team to build their confidence and attain their individual biophysical and behavioural health goals.

Interdisciplinary care that supports best practice treatment, prevention of disease, reduction of adverse events, health complications and the need for surgical interventions will improve population health, quality of life, reduce health care costs and will save lives.

Build Confidence and Skills of Consumers and Caregivers to Decrease their Risk and Effectively Manage their Vascular Disease

It is estimated that people with chronic conditions only visit a health care provider for approximately 12 hours per year – therefore 364.5 days of the year consumers and their family/friend caregivers take the lead in the management of vascular disease and other chronic health conditions.

Self-Management Training for Consumers and Caregivers builds skills and confidence (self efficacy) in managing chronic conditions. Self Management training and skill building for consumers and caregivers is fully accomplished when health service providers have the skills and tools (self management support) to enable their clients to effectively manage their conditions.

The Canadian Heart Health Strategy – Action Plan to Achieve our Goal

The Canadian Heart Health Strategy – Action Plan (CHHS-AP 2009) was developed to guide the reduction of the growing burden and loss due to vascular disease in Canada. The Strategy provides guidance to client, clinician and health service provider ground-level strategies to reduce the impact of vascular disease on individuals and the health care system. Despite being called the *Heart* Health Strategy, the CHHS recognizes the importance of preventing all vascular diseases regardless of the organ affected. More information on the CHHS can be obtained at www.chhs-scsc.ca

Central East LHIN's Strategy to Reduce the Impact of Vascular Disease

Following the continuum for chronic disease prevention and care, below are the partnerships, strategies and known initiatives that will help us achieve this strategic aim.

Prevention and Primary Health Care

Partners

Ministry of Health and Long-Term Care / Public Health Units / Ministry of Health Promotion / Primary Health Care / Community Health Centres / Community Support Services/ Unattached Patient Programs / Hospitals / Mental Health and Addictions Providers / Aboriginal Communities and Health Advisory Circle / Individuals, Families and Caregivers

Strategies

- Prevention, early identification and screening for vascular disease
- Support expansion of Primary Care with the Ministry of Health and Long-Term Care
- Reduce the number of unattached primary care clients and/or provide screening, assessment and referral
- Partner with other ministries and industry partners to promote healthy lifestyles
- Metabolic disease screening for people entering Community Mental Health and Addictions Programs or an Acute or Tertiary In-Patient Unit to identify those with or at risk of developing diabetes
- Work in partnership with Aboriginal communities to develop and implement a comprehensive vascular disease screening, assessment and management strategy that includes chronic kidney (renal) disease, metabolic syndrome and diabetes

Projects

- Expansion of best/promising practices for Renal Chronic Disease Prevention and Management (Renal CDPM) through early identification, screening and effective disease management for people with chronic kidney disease
- Assessment, Triage and Referral of Unattached Patients to identify asymptomatic disease and provide referral to community and/or specialist resources
- Leveraging the Ontario Shores Metabolic Screening Program to provide outreach support and increasing the capacity of Diabetes Education Centres/programs to support people with mental health and addictions
- Others as identified

Acute Care Treatment

Partners

Primary Health Care providers / Hospitals / Emergency Management Services / Ministry of Health and Long-Term Care / Other LHINs / Cancer Care Ontario

Strategies

- Continue with the implementation of the One Acute Care Network to improve equitable and timely patient access to an integrated hospital system that provides the highest quality of care across the Central East LHIN

Projects

- Enhancements and integration of regional Cardiac and Vascular Programs in the Central East LHIN
- Continued implementation of the Central East Unified Stroke System which will have improved access to Telestroke on-call support for area hospitals and an improved ability to access Enhanced District Stroke Centre and Regional/Tertiary Stroke Centre supports for LHIN residents
- Continued implementation of the Central East LHIN Renal Network to promote best practices, common reporting and organ transplant care
- Others as identified

Secondary Prevention of Disease Progression & Adverse Events

Partners

Hospitals / Community Care Access Centre / Community Support Services / Primary Health Care providers / Rehabilitation Providers/ Industry and Chronic Disease Associations / Individuals, Families and Caregivers

Strategies

- Support consumers and caregivers to effectively manage their chronic conditions in partnership with their health care team
- Improve access and coordination of care by building interdisciplinary care delivery teams and partnerships/coalitions between community agencies, hospitals, pharmacy, primary and specialty care providers, allied health professionals and non-health funded community providers such as education, social services and business
- Improving supports in community and primary care settings to reduce avoidable or non urgent/less urgent Emergency Department visits for vascular diseases, including ED visits related to completion of routine lab-work
- Reducing hospital in-patient admissions and re-admissions for complications of vascular disease that could have been managed effectively elsewhere in a community or primary care setting

Projects

- Creation of an integrated Cardiopulmonary Rehabilitation program across the LHIN
- Continue Self Management Training opportunities for Consumers and Caregivers and expanded capacity for follow-up
- Development of Self Management Support tools/toolkit to better enable health care providers/clinicians to support their clients to self-manage their chronic conditions
- Monitor, test and spread the Peterborough Comprehensive Vascular Disease Prevention and Management Initiative (CDVPMI)
- Address relevant recommendations of the Central East LHIN Rehabilitation Services Report and pursue integration opportunities and enhancements
- Others as identified

Policy and System Design

Partners

Ministry of Health and Long-Term Care / eHealth / Hospitals / Community Care Access Centre / Community Support Services / Primary Health Care providers / Individuals, Families and Caregivers

Strategies

- Support local implementation of the Ministry of Health and Long-Term Care's Diabetes Strategy, specifically through the regional coordination of diabetes programs
- Pursue service enhancements to increase to 50% the proportion of people with diabetes supported by primary care and specialty resources such as Diabetes Education Centres
- Pursue eHealth strategies that will support integration of clinical care, self-management and performance monitoring of chronic disease management
- Increasing consumer, caregiver and clinician capacity to follow best practice care guidelines and achieve recommended health outcome targets
- Integration/coordination and improved consistency of service delivery across the Central East LHIN

Projects

- Continue to distribute the Living Well with Diabetes – Resource Guide and develop complementary tools to continue to support the uptake of best practice and self care
- Improve coordination and consistency of the service delivery system that supports people with diabetes across Central East LHIN
- Integration eHealth projects that provide: a complete picture of the patient record (e.g., HIS Consolidation); Prevention support (e.g., e-learning, web portal; Disease management (e.g, Diabetes indicator project pilot) and Measurement Support (e.g., Clincial Documentation standardization)
- Others as identified

How Will We Measure Success for the Vascular Aim?

Various indicators can be considered to assess the impact of vascular disease on individuals and the health care system. To improve quality, indicators that address the Triple Aim dimensions of cost, population health and patient experience should be selected and pursued simultaneously.

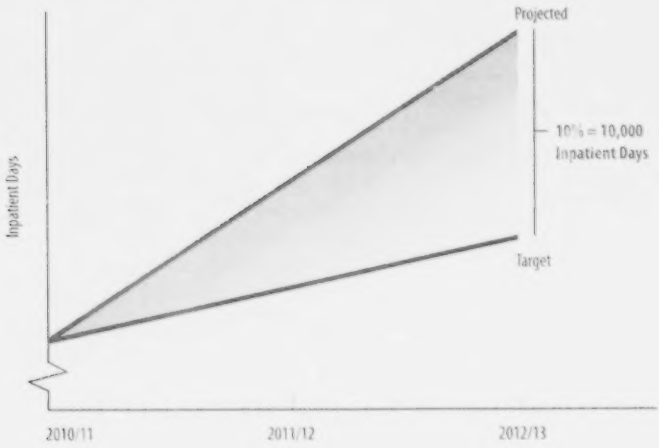
To serve as a proxy measure of the success of our collective strategies, we aim to monitor and reduce hospital utilization as measured by in-patient days (including ALC and acute days) by 10% by the end of 2013.

In 2008/09 Central East LHIN residents spent a total of 98,456 days in hospital as a result of their vascular condition. Based on population projections, the anticipated total number of patient days related to vascular conditions will be:

- in 2009/10: 100,936 patient days
- in 2010/11: 103,357 patient days
- in 2011/12: 105,856 patient days
- in 2012/13: 108,538 patient days

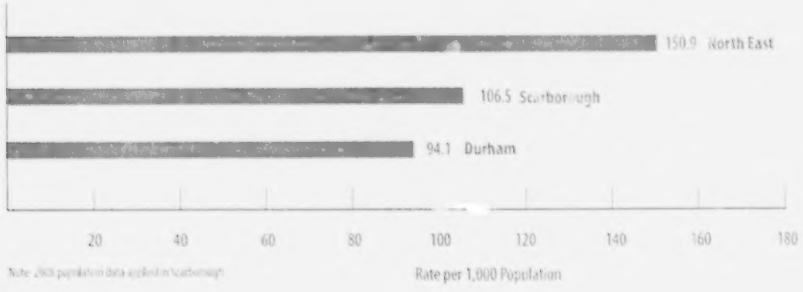
Using the 2008/09 as the benchmark year in which the 10% reduction is calculated, it is our collective target to save an accumulative 10,000 hospital in-patient days related to vascular conditions by 2012/13.[24] Saving these patient days will be a system-level indicator of our strategic aim to reduce the burden of vascular disease by 10% by the year 2013. Future indicators will be included as part of the Ontario Diabetes Strategy.

Measuring Our Aim – Reduce the Impact of Vascular Disease in the Central East LHIN by 10% by 2013.



Achieving this aim and the corresponding performance target may not occur uniformly across the Central East LHIN. Rather, we will need to address inequity in health outcomes and health care utilization between our priority populations and the three clusters of the LHIN. The graph below compares the rate of days spent in hospital for vascular related conditions by Central East LHIN residents by their place of residence. Rate is calculated as days spent in hospital per 1,000 people living in each cluster, as such residents of the North East cluster spent more days in hospital for vascular conditions per 1,000 population than other areas of the LHIN.

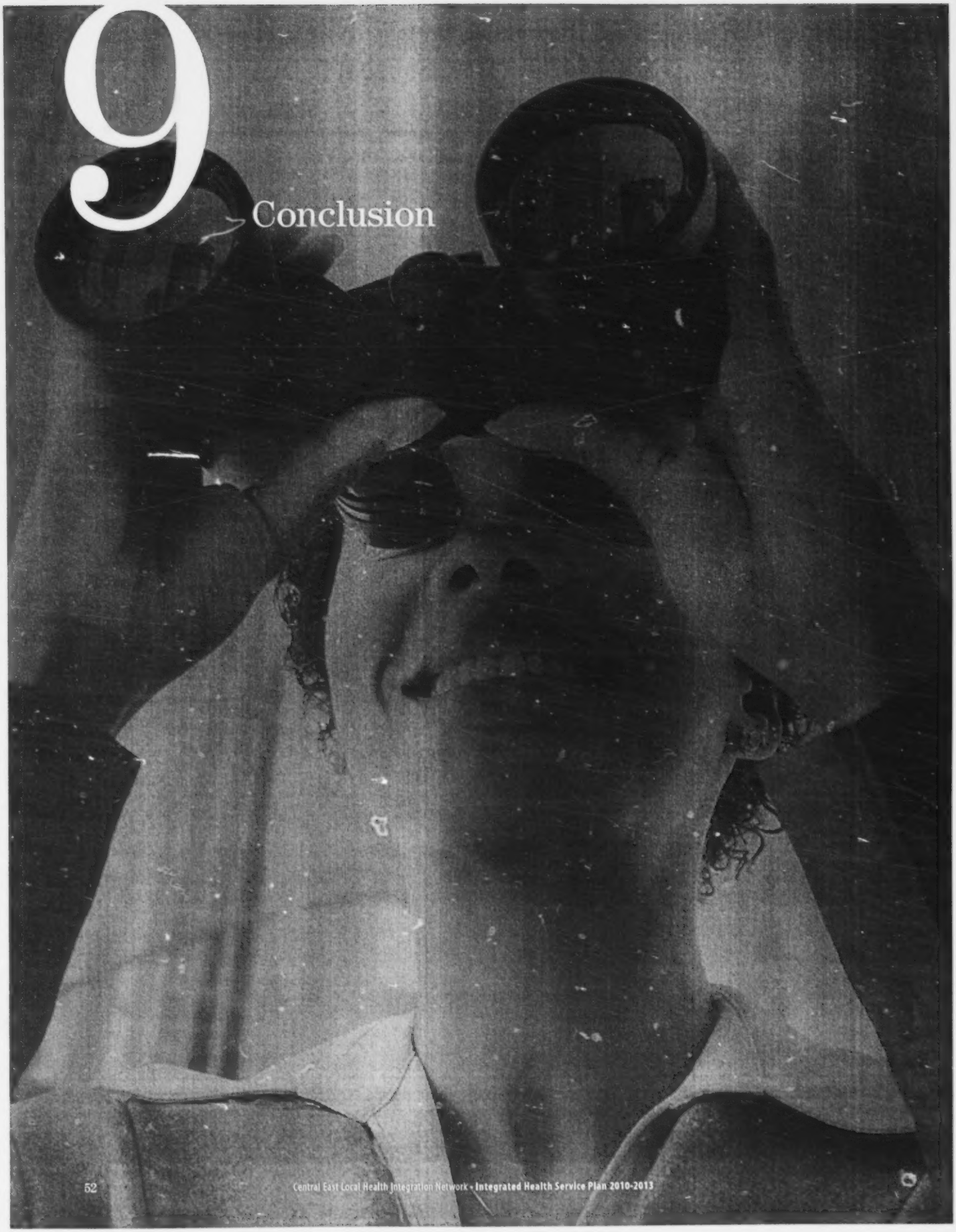
Rate of Vascular Inpatient Days for CE LHIN Residents per 1,000 population (2008/09)



Note: 2008 population data applied to Scarborough

24 98,456 x 10% = 9,846 days. This has been rounded up to 10,000.

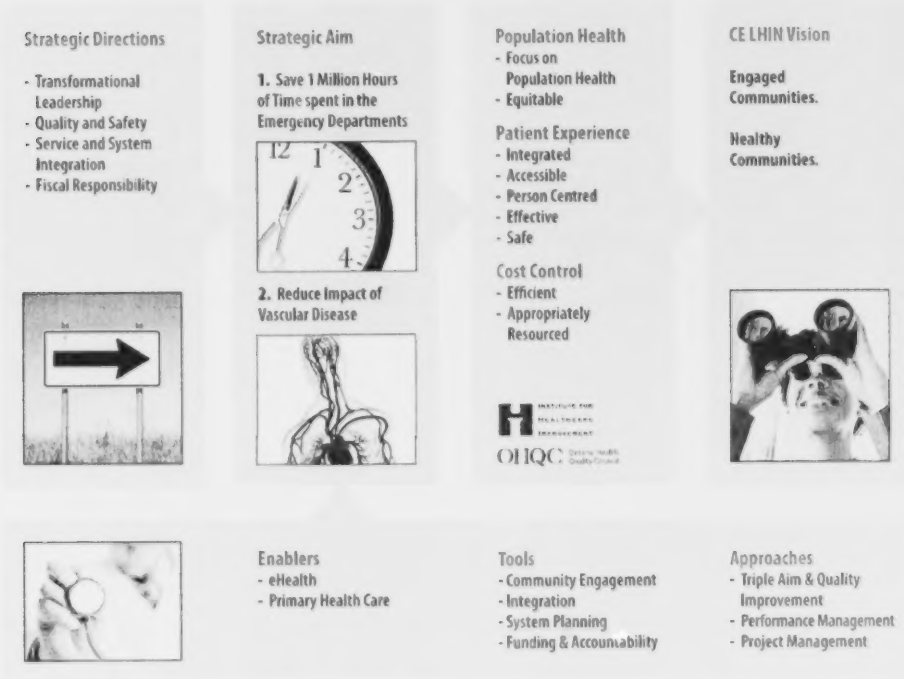
9 Conclusion



Conclusion

Having arrived at the conclusion of this plan, we can now fully complete the 2010-2013 Integrated Health Service Plan Strategy Map. The 2010-2013 IHSP Strategy Map visually captures the momentum as together we move from the starting point provided by the LHIN Strategic Directions to working with our priority populations to reach our Strategic Aims. The accomplishment of these Strategic Aims will be measured and evaluated using the Triple Aim Framework and the Attributes of a High Performing Health System. Supporting our accomplishments are key enablers, tools and approaches. By following this Strategy Map, we achieve the vision of *Engaged Communities. Healthy Communities.*

2010-2013 Integrated Health Service Plan Strategy Map



Building on the knowledge gained and lessons learned from both success and failures experienced in the last three years, the 2010-2013 Central East LHIN Integrated Health Service Plan looks forward with confidence to the achievement of two strategic aims that will significantly propel the Ministry of Health and Long-Term Care and Central East LHIN vision and strategic directions. More importantly, these aims will result in better health, better patient and client experience of health care, and better value-for-money for you, your community and your health care system.

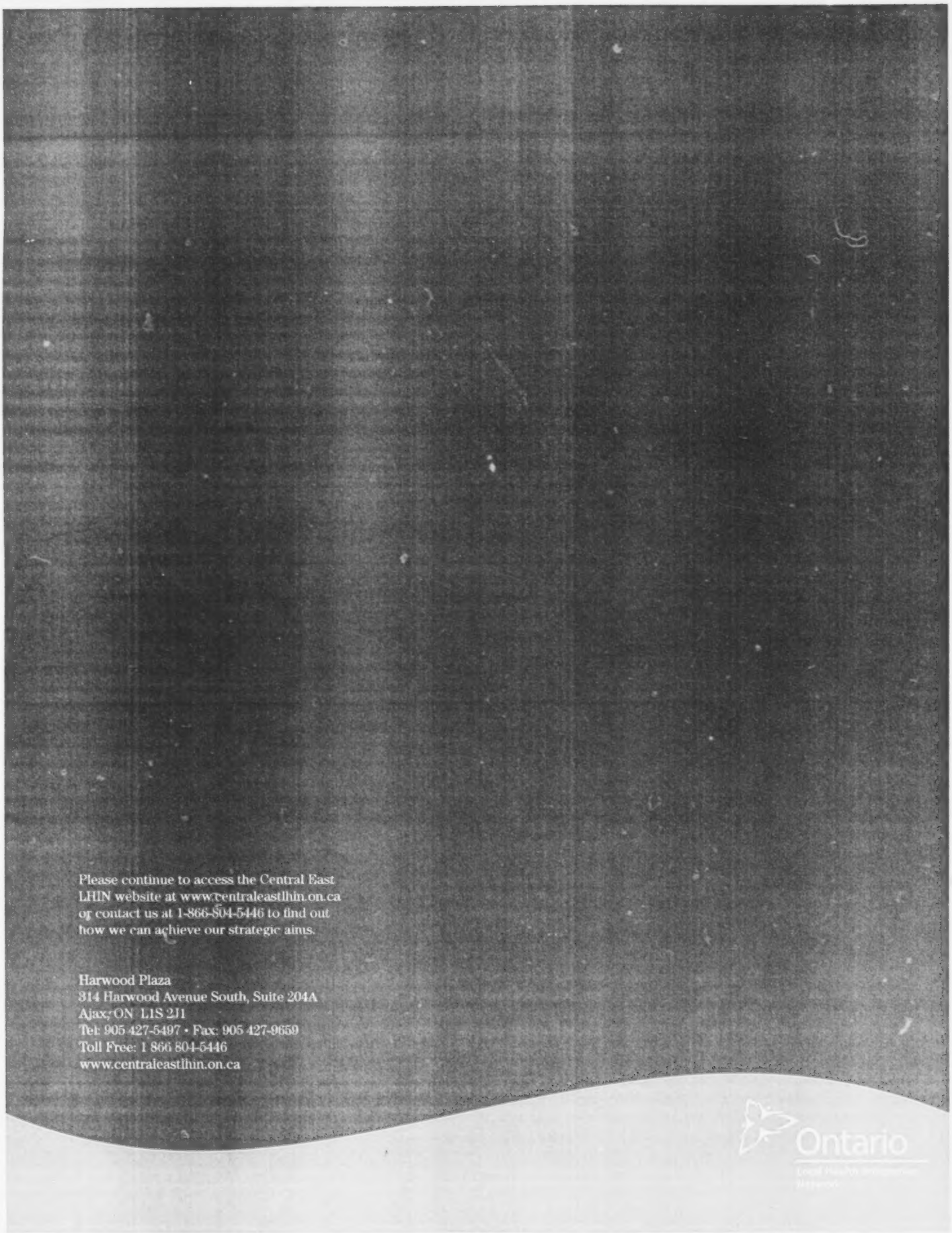
While we cannot underestimate the impact that the current economic challenges and recovery will have on our health care system and communities, now is a time to be clear about priorities and aims. This IHSP has provided clarity on aims, by how much and by when. They have also been validated by the public.

As the local system integrator, we have taken on the responsibility of achieving the "Triple Aim" by a commitment to work across the health care system, work closely with primary health care, and by reaching out to other organizations and social services in the attainment of our strategic aims. This is the value-add that LHINs have brought and will continue to bring to the Ontario health care landscape.

Not only does the achievement of these strategic aims require the commitment of our health service providers – from boards to front-line health care professionals – it also requires the participation of patients, families and communities.

Solutions must not only start and end with the patient experience, they must also take advantage of the commitment that individuals can make to their own health and health care needs. Everyone can directly make a contribution to the achievement of these goals and we want to hear your stories on what is working and what is not, and what changes you are making to achieve these goals.

We hope you agree that the 2010-13 Integrated Health Service Plan marks a significant advancement of the Central East LHIN vision of *Engaged Communities. Healthy Communities.*



Please continue to access the Central East LHIN website at www.centraleastlhin.on.ca or contact us at 1-866-804-5446 to find out how we can achieve our strategic aims.

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